STATEWIDE STANDARDS FOR HIV MEDICAL CASE MANAGEMENT

Washington State 2011

HIV Client Services
PO Box 47841
Olympia, WA 98504-7841
360-236-3457
Fax: 360-664-2216

Washington State Department of Health
430-023

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER WASHINGTON

For persons with disabilities this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

This document can be downloaded from: www.doh.wa.gov/cfh/hiv/care/casemanage/default.htm

This page left blank intentionally

Statewide Standards for HIV Medical Case Management

Washington State 2011

Acknowledgements

The Washington State Department of Health (DOH) HIV Client Services Program would like to express our gratitude to the Case Management Planning and Evaluation Group (CMPEG) and others who contributed to the creation of these Standards:

- Richard Aleshire — Washington State Department of Health
- Karen Robinson — Washington State Department of Health
- Jeff Natter — PHSKC Public Health-Seattle & King County
- Christina Benavides — Chelan-Douglas Health District
- Joan Clement — Harborview Madison Clinic
- Katie Coker — Spokane AIDS Network
- Jodi Dumont — Pierce County AIDS Foundation
- Sarah Fanucci — Evergreen AIDS Foundation
- Staci Sturges — Clark County Public Health
- Rebecca Hutcheson — PHSKC Public Health-Seattle & King County
- Richard Prasad — Country Doctor Community Clinic
- Jill Dickey — Blue Mountain Heart to Heart
- Melanie Lainez — Consejo Counseling & Referral Service
- Timm Cameron — Lifelong AIDS Alliance
- Ann Willis — Spokane Regional Health District
- Barbara Ward — Clallam County Health & Human Services

A special acknowledgement is given to Neil Good, Statewide Case Management Coordinator of DOH who worked diligently to ensure that these Standards were revised. In addition Anneke Jansen, Statewide Quality Management Coordinator of DOH; Amber Whitcher, Community Planning Coordinator of DOH; and Abby Gilliland, Community Programs Contracts Coordinator of DOH were instrumental in providing significant professional recommendations.

This page left blank intentionally

Table of Contents

Introduction

The HIV/AIDS continuum of care is a complex network of medical and social service agencies that can be challenging for people living with HIV to navigate. Case managers play a vital role in helping clients navigate and access HIV/AIDS care.

Case managers assist clients in addressing barriers while providing services that are flexible to the client's current medical and social needs. Medical case management reflects a philosophy that affirms a client's right to privacy, confidentiality, respect, nondiscrimination, dignity and self-determination.

Development of Standards

Medical case management is provided in a variety of settings in Washington State. These settings include AIDS service organizations, health departments, and medical facilities. This variety means that medical case management is able to effectively support clients with different needs and backgrounds as well as clients who are at different stages in their illness. However, the variety of settings also provides a challenge of creating a set of standards that will be relevant and applicable for all agencies providing HIV medical case management.

The Washington State Department of Health's (DOH) HIV Client Services program recognized the need for a set of standards that would ensure that agencies across the state were providing a core set of medical case management functions for clients and a way to evaluate these services. In November of 2004 the Case Management Planning and Evaluation Group (CMPEG) was formed to provide guidance to DOH for medical case management related issues. The first goal was that of creating medical case management standards that ensure consistent medical case management practices regardless of where services are delivered. This group included case managers, with representation from Ryan White Parts A, B, C and D, as well as the Washington State AIDSNETs. CMPEG provided invaluable vision and guidance in the development of the medical case management standards.

In August 2010 the DOH Community Programs staff recognized a need to revise/update the medical case management standards. After the Community Programs staff at DOH completed an initial revision of the medical case management standards, CMPEG was re-convened in January 2011 to provide guidance and to review the revised standards.

The medical case management standards describe the minimum standard of care that is essential to begin to meet the needs of people with HIV. These standards are not an interpretation of the law. If your agency receives Title XIX funds, review the HIV/AIDS Case Management Billing Instruction manual.

HIV Medical Case Management

The overall objectives of medical case management are to:

- Provide linkage to a high quality of care through experienced and trained case managers
- Gather information to assess and determine each client's needs
- Develop and implement a service plan

The goal of medical case management is to help clients gain and maintain access to primary medical care and treatment. In the process of meeting this goal, case managers must assess and facilitate each client's progress toward self-sufficiency.

Medical case management is a formal and professional service that links clients with chronic conditions and multiple service needs to a continuum of health and social service systems. Medical case management strives to ensure that clients with complex needs receive timely coordinated services, which assist a client's ability to function independently. Medical case management assesses the needs of the client, their support system, including family and others, and arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the client's needs.

According to the Health Resources and Service Administration (HRSA), the Ryan White Care Act defines medical HIV case management as:

> "Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. These services ensure timely and coordinated assess to medically appropriate levels of health and support services and continuity of care, through an ongoing assessment/re-assessment of the client and other key family member's needs and personal support systems. Medical case management may also include the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the care plan; and (5) periodic re-evaluation and adaptation of the care plan, at least every six months, as necessary during the enrollment of the client."

Statewide Standards for HIV Medical Case Management

Washington's Statewide Standards for HIV Medical Case Management apply to programs providing Ryan White or Title XIX Targeted HIV Case Management services. The Standards establish the minimum requirements that programs must follow. Providers may exceed these standards.

Important Definitions

Active Status
Describes the timeframe for clients who have ongoing need for medical case management involvement to ensure access to and maintenance in HIV medical care, adherence to HIV medications, and linkage with primary and secondary support services.

Activities of Daily Living (ADL)
Tasks required for a person to live independently, meet their basic needs, and access medical care. ADLs may include but are not limited to eating, bathing, dressing/undressing, meal preparation and clean-up, walking, getting in/out of bed, controlling urine and bowel functions, dressing oneself, paying essential bills such as rent/utilities, and using the toilet.

Adherence
The extent to which a patient/client continues the agreed-upon mode of treatment or intervention as prescribed. Medication adherence means taking medication exactly as prescribed by the healthcare provider. This includes taking the correct taking medication exactly as prescribed by the healthcare provider. This includes the taking the correct number of pills at the correct time of the day/night and in accordance with any special instructions (e.g., restrictions on food and/or liquid intake when taking pills). Failure to adhere to medications may result in a mutation in the virus that can make the medication ineffective.

AIDS
AIDS stands for Acquired Immune Deficiency Syndrome. HIV disease becomes AIDS when the patient's immune system is seriously compromised. Clinicians determine an AIDS diagnoses by testing and analyzing the patient's CD4 count. If the person has less than 200 CD4 cells, he or she is given the medical diagnosis of AIDS. In addition, if a patient has certain HIV-related illnesses they could also be given a diagnosis of AIDS even if their CD4 count is above 200.

Anti-Retroviral Medication (ARV)
ARV refers to the different types of medications prescribed specifically to slow/control the production of HIV in the blood.

Best Practice
A technique, methodology, or action that through experience and/or research has proven to lead to a desired result. Best practices may include performance recommendations that assist agencies in meeting or exceeding the set guidelines/standard.

Brief Status
Describes a limited engagement with a client who has a one-time or brief need for medical case management involvement. Typically a brief status describes those clients who request information or referrals without need for ongoing medical case management follow up and are able to independently access and maintain HIV medical care, access health coverage without ongoing medical case management assistance, initiate referrals and follow through on their own behalf. These clients do not have ongoing needs for support service referrals/linkages. This status can change to "active" when a client's needs for increased and ongoing engagement increase.

CD4 Cell
CD4 cells are a type of white blood cell that helps the body to fight off infection. The HIV virus destroys CD4 cells and after a period of time leaves the body vulnerable to infection.

CD4 Count
CD4 count or tests help health care providers to determine how badly the HIV virus has damaged the patient's immune system. CD4 cell tests are normally reported as the number of cells in a cubic millimeter of blood, or **cells /mm^3**; or as the percentage of white blood cells that are CD4 cells. There is some disagreement about the normal range for CD4 cell counts, but normal counts are between 500 and 1600 cells/**mm^3** A CD4 count below 200 is generally considered the clinical marker for an AIDS diagnosis.

Discharged Status
Describes either the timeframe for clients who were, at one time, "active" but have met the criteria for case closure (as outlined in the agency's case closure policy) or describes clients who have disengaged from the medical case management services for 12 months or longer. These clients may re-engage, as described under the "new status".

Homelessness
For purposes of this guideline term "homeless" or "homeless individual or homeless person" includes:

- An individual who lacks a fixed, regular, and adequate nighttime residence;
- An individual who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
- An institution that provides a temporary residence for individuals intended to be institutionalized; or
- A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Inactive Status
Describes the timeframe for those clients who continue to have ongoing need for medical case management, but are currently disengaged from medical case management services for 12 months or less. Examples include clients who are migrant workers or clients who are homeless and have extended periods between engagements with medical case management.

Mental Illness
A medical disorder(s) that impairs a person's thinking, mood, sensory perception, relationships to others, and/or daily functioning. Treatment for mental illnesses may require medication, vocational or psychosocial rehabilitation services and therapeutic counseling.

Mental Health
Mental health describes the client's overall psychological status and well-being including emotional and cognitive health. Mental health is used also to describe the professions (e.g. clinical social workers, psychologists, and psychiatrists) that assist people to achieve overall mental health.

New Status
Describes the timeframe for those clients who are presenting for the first time or are re-engaging with active medical case management after having been on "discharged" status.

Newly Diagnosed
Any individual recently diagnosed with HIV or AIDS. Individuals newly diagnosed with HIV/AIDS may need support to successfully connect to a medical home, to develop a positive support system to help cope with the emotional and physical impact of an HIV/AIDS diagnosis, to learn about HIV disease and what that means for them individually, and to learn about new medications and disease management.

Opportunistic Infection (OI)
Illnesses caused by various organisms, some of which do not cause disease in persons with normal immune system. An illness that only becomes infectious when a person's immune system is compromised. Persons living with advanced HIV infection suffer opportunistic infection of the lungs, brain, eyes and other organs, common with diagnosis of AIDS including Pneumocystis carinii pneumonia (PCP), Kaposi's sarcoma, Cryptosporidiosis, histoplasmosis, Candidaisis, other parasitic, viral and fungal infections and some type of cancers. The number of OIs has decreased with the advent of modern ARV therapies, but can become problematic for individuals diagnosed late in his/her disease progression or others who have otherwise progressed to an AIDS diagnosis.

Risky Behavior
Behaviors that create an increased opportunity for a person to be exposed or to expose others to the HIV virus. Risky behaviors include but are not limited to unprotected oral, anal, or vaginal sex; sharing of needles; multiple sex partners; and breastfeeding if the mom is HIV positive.

Transition Status
Describes the timeframe when a client transitions to another program/provider for medical case management services.

Viral Load
Viral load is a measure of the amount of HIV virus in the client's blood. Measuring the viral load is part of monitoring how a patient is responding to medications and how far their disease has progressed. The results of these tests are usually given as the number of HIV RNA copies per milliliter (ml) of blood. Successful antiretroviral therapy should cause a fall in viral load of 30-100 fold within six weeks, with the viral load falling below the "limit of detection" or becoming "suppressed" within four to six months. A suppressed viral load usually refers to a viral load level that is below a certain number or below the limit of detection. It may be written as "suppressed to below x number of copies" or just "suppressed". Unsuppressed viral load implies that there is detectable virus or it is above a certain threshold. Non-adherence to medication is one of the major causes of an unsuppressed viral load.

This page left blank intentionally

Standard 1.0 - Policies and Procedures

The objective of the policies and procedures standard is to ensure that agencies have policies and procedures in place that:

- Establish client eligibility
- Guarantee client confidentiality
- Define client rights and responsibilities
- Outline a process to address client grievances
- Reassess client eligibility
- Address client transition or discharge

1.1 Eligibility Policy

Agencies must establish client eligibility policies that comply with state and federal regulations. These include screening of clients to determine eligibility for services within 30 days of intake. Agencies must have documentation of eligibility in clients' records including proof of HIV status, residence, income, and health coverage status.

HIV or AIDS Diagnosis

Clients must be HIV positive to receive Ryan White Part A or B services. Agency policy must require one of the following documents to verify HIV or AIDS diagnosis:

- Original Western Blot test results
- Original lab report showing measurable presence of HIV virus
- Signed letter/form from medical provider who has been providing care stating client is HIV positive

Residency

A client must be a Washington state resident to receive Medicaid Title XIX HIV Medical Case Management services. A client must be a resident of Seattle TGA (King, Island & Snohomish Counties) to receive Ryan White Part A services. A client must be a resident of Washington State and live outside the Seattle TGA to receive Ryan White Part B services.

Agency policy must require one of the following documents to verify Washington State residency:

- Current Washington state driver license or official state ID
- Washington state voter registration card
- Utility bill (cell phones not accepted)
- Lease/rental/mortgage agreement
- If a client is homeless, a signed statement from the client documenting where they slept the previous night

Income

Agency policy must require verification of clients' current available income and family size. Available income must account for income of other family members living in the residence. According to the Early Intervention Program (EIP) family size is "*based on the people in the applicant's family that live with*

them. Applicants must declare "Yes" or "No". If applicant selects "Yes" that they have a legally married spouse or Washington State registered domestic partner and/or dependent children under the age of 18 who live with them, they must list those family members, relationship, and date of birth & answer the income question. Applicants should not include roommates."

Agency policy must require one of the following to verify income:

- Check stub
- Unemployment stub
- Monthly benefit statement
- Annual benefit statement
- Bank statement showing direct deposit amounts
- Profit & loss statement
- Child support order

Health Coverage Status

Agency policy must require verification that a client is insured or underinsured using a copy of the medical or dental insurance card (front & back). Underinsured is defined as having insufficient insurance coverage for the clients medical and prescription needs.

1.2 Confidentiality Policy

A confidentiality policy protects clients' personal and medical information such as HIV status, behavioral risk factors, and use of services. Medical case management agencies must have a confidentiality policy that aligns with state and federal laws (WAC 388-539-0300/0350). The confidentiality policy must include consent for release of information, duty to warn, and storage of client records.

Release of Information (ROI)

As part of the confidentiality policy, all agencies must develop an ROI[1] form that describes the circumstances under which an agency can release client information. ROIs must be renewed at a minimum of once every 12 months, but a client may withdraw an ROI at any time, either verbally or in writing. The ROI must include all of the following components:

- Purpose of disclosure
- Name of agency or individual with whom information can be shared
- Types of information to be shared
- Client signature

The ROI form must be in accordance with:

- RCW 70.02.030 (Medical Records – Patient Authorization for Disclosure)
- WAC 388-539-0300 (Case Management for Persons Living with HIV/AIDS)

If an agency is covered by the Health Insurance Portability and Accountability Act (HIPAA), the release of information form must be a HIPAA-compliant disclosure authorization.

[1] An example of an ROI is located in Appendix I

Duty to Warn

As part of the confidentiality policy, all agencies must include a duty to warn statement that describes the circumstances under which an agency can release client information without client consent. Duty to warn refers to the responsibility of a case manager to breach confidentiality if a client or other identifiable person is in clear or imminent danger. In situations where there is clear evidence of danger to the client or other persons, the case manager must determine the degree of seriousness of the threat and notify the person in danger and others who are in a position to protect that person from harm. However, per RCW 71.05.120 if the case manager has reasonable suspicion of the threat, duty to warn protects him or her from prosecution.

Client Files

To prevent unauthorized persons from accessing confidential information, case managers must secure physical and electronic client files in a manner that meets minimum HIPAA Standards. Security of client files and records must be part of the agency's confidentiality policy.

If an agency transports client files outside their agency they must be transported in a locked container and never left unattended. Electronic media (disks, data sticks, etc.) used to transport confidential information must be de-identified or encrypted (using federal encryption standards) before leaving an agency.

1.3 Client Rights and Responsibilities Policy

Active participation in one's health care and sharing in health care decisions maximizes the quality of care and quality of life for people living with HIV/AIDS. Case managers can facilitate this by ensuring that clients are aware of and understand their rights and responsibilities. Agencies must have a client rights and responsibilities policy that ensures:

- Medical case management services are accessible to clients
- Medical case management services are available
- Freedom of choice as specified under Title XIX
- Consumers involvement in the design and evaluation of HIV/AIDS services
- Clients rights and responsibilities as consumers of HIV/AIDS services

MCM Service Accessibility

HIV/AIDS services funded by Ryan White or Title XIX Targeted HIV Case Management must be accessible to all clients who meet eligibility requirements. Agencies must provide services in a setting accessible to low-income individuals with HIV. Agencies must comply with the Americans with Disabilities Act (ADA) requirements

Agencies must document how they promote HIV services to low-income individuals. Documentation must include copies of HIV program materials that promote services and explain program eligibility requirements. In addition according to the National Standards on Culturally and Linguistically Appropriate Services (CLAS)[2] agencies must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups or groups represented in the service area.

[2] The CLAS Standards are located in Appendix XVI

Medical Case Management Service Availability

Agencies must provide services to eligible clients regardless of the client's ability to pay for the service and the client's current or past health condition. Agencies must have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services. Agencies must maintain files of eligible individuals refused services with reasons for refusal specified. Agency files must include formal complaints from clients, with documentation of complaint review and decision reached.

Access to Files

Agencies must provide clients with their policy for record/file access.

Client Input and Feedback

Agencies must incorporate client input and feedback into the design and evaluation of medical case management services funded by Ryan White and Title XIX HIV Case Management. Agencies can accomplish this through:

- Consumer advisory boards
- Consumer participation in HIV program committees or other planning bodies
- Needs assessments, focus groups, or satisfaction surveys that collect information from consumers to help guide and evaluate service delivery

1.4 Grievance Policy

An agency's grievance policy must outline a client's options if he or she feels that the case manager or agency is treating him or her unfairly or not providing quality services. The grievance procedure must be posted and visible to clients and include:

- Steps a client must follow to file a grievance
- Agency procedure for handling grievances
- Information on how a client can appeal the decision if the grievance is not settled to his or her satisfaction

1.5 Reassessment of Eligibility

Agencies must establish policies for reassessment of clients every 6 months to determine continued eligibility. Policy must include accepted eligibility documentation for residence, income, and health coverage status.

1.6 Transition/Discharge Policy

Agencies must have a transition/ discharge policy that outlines how they attempt to achieve continuity of care for clients leaving an agency and reasons for discharging clients.

Standard 1.0 Policies and Procedures	
STANDARD	**MEASURE**
1.1 Eligibility Policy	
a. Case management eligibility policy exists	a. Policy on file at the provider agency
b. Eligibility policy addresses HIV or AIDS diagnosis requirements	b. Policy complies with state & federal guidelines
c. Eligibility policy addresses residency requirements	c. Policy complies with state & federal guidelines
d. Eligibility policy addresses income requirements	d. Policy complies with state & federal guidelines
e. Eligibility policy addresses health coverage status requirements	e. Policy complies with state & federal guidelines
1.2 Confidentiality Policy	
a. Client confidentiality policy exists	a. Policy on file at the provider agency
b. Client confidentiality policy is posted	b. Policy is posted in a visible location
c. ROI form exists	c. Form on file at the provider agency
d. Duty to warn statement exists	d. Statement included as part of ROI
e. Files are stored in a secure and confidential location	e. Files stored in a locked file or cabinet with access limited to appropriate personnel
f. Electronic client files are protected from unauthorized use	f. Electronic files password protected with access limited to appropriate personnel
1.3 Client Rights and Responsibility Policy	
a. Client rights and responsibility policy exists	a. Policy on file at the provider agency
b. Client rights and responsibility policy is posted	b. Policy is posted in a visible location
c. Services are available to any individual who meets program eligibility requirements	c. Documentation of individuals refused services with reasons specified
d. Freedom of choice of provider policy exists	d. Policy on file at the provider agency
e. Services are accessible to clients	e. Agency description submitted to funder
f. Programs include input from clients in the design and evaluation of service delivery	f. Documentation of meetings of client advisory board, client involvement planning and evaluation
g. Clients right to access file policy exists	g. Policy on file at the provider agency
1.4 Client Grievance Policy	
a. Client grievance policy exists	a. Policy on file at the provider agency
b. Client grievance policy is posted	b. Policy is posted in a visible location
1.5 Reassessment of Eligibility Policy	
a. Reassessment of eligibility policy exists	a. Policy on file at the provider agency
1.6 Transition/Discharge Policy	
a. Agency has a transition/discharge policy	a. Policy on file at the provider agency

This page left blank intentionally

Standard 2.0 Personnel

The objective of the personnel standard is to ensure that case managers and their supervisors have:

- Clear and updated job descriptions
- An orientation
- Supervision
- Appropriate ongoing training opportunities
- Clinical Consultations
- Review of client files
- Training in cultural competency

Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. Staff must have previous experience, or a plan for acquiring experience, in providing case managements services.

2.1 Job Descriptions

Case managers and their supervisors must receive and sign a written job description that outlines the specific minimum requirements for their position.

The supervisor's job description must state that they:

- Understand Statewide HIV Medical Case Management Standards and requirements
- Update case management staff job descriptions at least once every 12 months
- Have contact with case management staff at least 2 times per month
- Have education, knowledge and skills to support case management staff.
    - Bachelor's degree and 3 years relevant experience.

The case manager's job description must state that they:

- Have knowledge of HIV/AIDS care service delivery system or experience in related field
- That they receive regular, direct, supervision
- Have a Bachelor's degree and 1 year experience

2.2 Orientation

Agencies must provide a structured orientation within 1 month of hire. Orientation must address:

- Overall operation of the program and agency
- Job duties/responsibilities
- Agency policies and procedures
- Confidentiality
- Code of ethics
- Professional boundaries
- Introduction to local resources and programs
- Review of client eligibility and intake process
- Required documentation in client files

- Training needs and annual training requirements
- Quality management
- Coping with job related stress/preventing burnout
- Crises management

2.3 Supervision

Supervisors must provide case managers with guidance and supervision and must include:

- Meeting with case management staff at least 2 times per month
- Evaluating case manager's job performance at least once every 12 months

2.4 Training

Within 6 months of hire supervisors and case managers must attend DOH sponsored training on the Statewide HIV Medical Case Management Standards, and Introduction to state/federal resources and programs. In addition, case managers must receive a minimum of 20 hours of job related trainings per year. Examples of job related trainings include:

- Mental Health
- Chemical Dependency
- Medicaid
- Cultural Competency
- Confidentiality
- HIV Treatment and Trends
- Tobacco Cessation
- HIV Prevention
- Harm Reduction

2.5 Clinical Consultation

In addition to the trainings listed above supervisors must provide or arrange clinical case consultations with case management staff at least quarterly.

2.6 Review of Client Case Files

Supervisors will review a representative sample of all client case files quarterly for compliance with Statewide Standards for HIV Medical Case Management. In addition, peer review of client files is strongly encouraged.

2.7 Cultural Competence

Case managers and their supervisors must receive CLAS training to ensure the agency and their staff is in compliance with the CLAS standards. This is to ensure that services provided by case managers are culturally and linguistically appropriate. Training of CLAS standards must take place within 6 months of initial hire.

Standard 2.0 Personnel	
STANDARD	**MEASURE**
2.1 Job Descriptions	
a. Staff have written job descriptions	a. Written job descriptions in personnel file
b. Supervisors have Bachelor's degree + 3 years experience	b. Resume in supervisor's personnel file with copies of degrees, certifications, work history, trainings
c. Case managers have Bachelor's degree + 1 year experience	c. Resume in personnel file with copies of degrees, certifications, work history, trainings
d. Case managers have knowledge of HIV/AIDS care service delivery system or experience in related field	d. Documentation in case manager's personnel file, such as degrees, work history, position description, relevant certifications
2.2 Orientation	
a. Agency provides structured orientation within 1 month of hire	a. Documentation of orientation in case manager personnel file
2.3 Supervision	
a. Supervisor has contact with case management staff at least 2 times per month	a. Documentation of meetings (minutes, calendars, agendas) on file and available at provider agency
b. Supervisor evaluates case manager's job performance at least once every 12 months	b. Documentation of evaluation in personnel file
2.4 Training	
a. Supervisor completes DOH-sponsored training on Statewide HIV Medical Case Management Standards within 6 months of hire	a. Certification of completion of DOH sponsored training in supervisor's personnel file
b. Supervisor completes DOH-sponsored training on Introduction to state/federal resources and programs within 6 months of hire	b. Certification of completion of DOH sponsored training in supervisor's personnel file
c. Case manager completes DOH-sponsored training on Statewide HIV Medical Case Management Standards within 6 months of hire	c. Certification of completion of DOH sponsored training in case manager's personnel file
d. Case manager completes DOH-sponsored training on Introduction to state/federal resources and programs within 6 months of hire	d. Certification of completion of DOH sponsored training in case manager's personnel file
e. Case manager receives a minimum of 20 hours of annual training selected by supervisor and case manager	e. Documentation in case manager's personnel file
2.5 Clinical Consultation	
a. Supervisor provides or arranges clinical case consultations with case management staff	a. Documentation of meetings (minutes, calendars, agendas) on file and available at provider agency
2.6 Review of Client Case Files	
a. Supervisors reviews representative sample of client case files quarterly for compliance with standards	a. Documentation on file at provider agency
2.7 Cultural Competence	
a. Case managers and their supervisors are trained in CLAS standards within 6 months of hire	a. Copies of training verification in personnel file

This page left blank intentionally

Standard 3.0 Client Intake and Eligibility

The objective of the client intake and eligibility standard is to ensure that case managers:

- Collect basic client information
- Give client written information and explanation of agency policies and services
- Ensure clients meet the eligibility requirements
- Complete intake process within 2 weeks

3.1 Timeline

For each prospective client who requests Ryan White or Title XIX Targeted HIV Case Management services, case managers, or staff trained to screen and determine eligibility, must:

- Begin intake process within 2 weeks of initial contact (this is determined by the date when a client is first seen and requests case management services)
- Collect eligibility documentation within 30 days of initiating intake

3.2 Policies and Procedures

During the intake process, staff will:

- Obtain consent for case management services[3]
- Explain the agency's eligibility policy (Standard 1.1)
- Explain the agency's confidentiality policy (Standard 1.2)
- Explain the agency's client rights and responsibilities policy (Standard 1.3)
- Explain the agency's grievance policy (Standard 1.4)
- Explain agency's reassessment of eligibility policy (Standard 1.5)
- Explain the agency's transition/discharge policy (Standard 1.6)
- Explain client's freedom to choose a provider (Medicaid)
- Obtain client signatures on needed ROI Form(s)

3.3 Client Information

Case managers should use the intake process to gather basic demographic information and to identify the client's presenting problem. This information will assist the case management staff in determining if a client needs comprehensive case management, brief involvement or a discrete service. An agency's client intake form[4] must include the following client information:

- Name, address, and phone
- Preferred method of communication (e.g., phone, email, or mail)
- Emergency contact information
- Preferred language of communication
- Primary reasons and need for seeking services at agency
- Referral source

[3] An example of a Consent for Services form is located in Appendix I
[4] An example of a Client Intake form is located in Appendix II

If a client is currently on Antiretroviral Therapy (ART) medications, it is imperative to assess the client's needs for access to medications. Case managers should prioritize helping clients gain or maintain access to medications.

3.4 Eligibility

To establish eligibility, case managers must document and verify the following information:

- HIV or AIDS diagnosis
- Washington State Residency
- Income of client and all applicable family members (See eligibility policy guidance listed in Standard 1.1)
- Health Coverage Status

Eligibility Requirement	Examples of Acceptable Documentation
HIV or AIDS Diagnosis[5]	Original Western Blot test results Original lab report showing measurable presence of HIV virus Letter, with signature from physician that has been providing care, stating client is HIV positive
Washington State Residency	Current Washington state driver license Washington state ID Washington state voter registration card Utility bill (cell phone bills not accepted) Lease/rental/mortgage agreement Homeless Client Statement[6]
Income of client and all applicable family members	Pay Stub Unemployment stub Monthly benefit statement Annual benefit statement Employer W-2 Bank Statements showing direct deposit amounts Profit & loss statement Child support order No Income Statement Copy of Supplemental Security Income (SSI) Copy of Social Security Disability Checks (SSDI)
Health Coverage Status	Medical or dental insurance card (front and back)

[5] An example of a HIV/AIDS Verification form is located in Appendix III
[6] An example of a Homeless Client Statement is located in Appendix IV

Standard 3.0 Client Intake and Eligibility	
STANDARD	**MEASURE**
Case Manager will:	
3.1 Timeline	
a. Begins intake process with client within 2 weeks of initial contact	a. Documented in client chart or EMR
b. Screen client for eligibility and obtain verification within 30 days	b. Eligibility documentation obtained and included in client chart or EMR within 30 days of intake
3.2 Policies and Procedures	
a. Obtain consent for case management services	a. Documented in client chart or EMR
b. Explain eligibility policy	b. Documented in client chart or EMR
c. Explain confidentiality policy	c. Documented in client chart or EMR
d. Explain client right's and responsibility policy	d. Documented in client chart or EMR
e. Explain transition/discharge policy	e. Documented in client chart or EMR
f. Explain grievance policy	f. Documented in client chart or EMR
g. Explain reassessment of eligibility policy	g. Documented in client chart or EMR
h. Explain client's freedom to choose a provider	h. Documented in client chart or EMR
i. Obtain client signatures on needed ROI forms	i. Signed and current ROI's (within 12 months) in client chart
3.3 Client Information	
a. Name, address, and phone number	a. Documented in client chart or EMR
b. Preferred method of communication	b. Documented in client chart or EMR
c. Emergency contact information	c. Documented in client chart or EMR
d. Preferred language of communication	d. Documented in client chart or EMR
e. Enrollment in other HIV/AIDS services	e. Documented in client chart or EMR
f. Primary reason for seeking services at agency	f. Documented in client chart or EMR
g. Referral source	g. Documented in client chart or EMR
3.4 Eligibility	
a. Verify and document client's HIV positive status	a. Documentation of HIV positive status in client chart or EMR
b. Verify and document residency	b. Documentation of client's residency in client chart or EMR
c. Verify and document client and applicable family's income	c. Documentation of client's income in client chart or EMR
d. Verify and document client's health coverage status	d. Documentation of client's health coverage status in client chart or EMR

This page left blank intentionally

Standard 4.0 Comprehensive Assessment and Reassessment

The objective of the comprehensive assessment and reassessment standard is to ensure that case managers:

- Complete comprehensive assessment within 30 days of intake and every 5 years thereafter
- Gather information to determine client's needs in primary and secondary activity areas
- Confirm client's eligibility at least every 6 months
- Reassess client at least every 12 months

The purpose of a comprehensive assessment[7] is to gather relevant information that will facilitate the creation of an Individual Service Plan (ISP). The comprehensive assessment is a cooperative and interactive activity between the case manager and the client. The client is the primary source of information. However, with client consent, assessments may include additional information from medical or psychosocial providers, caregivers, family members, and other sources of information. The case manager is encouraged to contact other service providers/care givers involved with the client or family system in support of the client's well being. Case managers must comply with established agency confidentiality policies (see Standard 1.2) when engaging in information collection and coordination activities.

The case manager must sign and date the completed assessment and reassessment. Agencies using electronic medical records may use electronic signatures. The case manager does not need to print the assessment or reassessment. However, the client's paper chart must identify where the assessment is stored electronically.

4.1 Timeline

Case managers must begin and complete comprehensive assessments within the following timeframe:

- A comprehensive assessment must begin within 2 business days of intake
- A comprehensive assessment must be completed within 30 days of intake
- A new comprehensive assessment must be completed every 5 years

4.2 Comprehensive Assessment – Primary Activity Areas

It is essential to capture information about a client's general medical history as well as the specifics of his/her HIV disease status and history of opportunistic illnesses. Assessing the client's history and ability to adhere to HIV medications is critical to medical case management services. Case managers should also assess for co-occurring physical health problems such as TB, hepatitis, or sexually transmitted infections. Case managers must assess the client's history and current needs in these primary activity areas:

- Entitlement program benefits such as Medicare, Medicaid, Veteran's Administration
- HIV medical management services: HIV Early Intervention Program (EIP), Evergreen Health Insurance Program (EHIP)
- Primary medical care
- Medication
    - Medication list
    - Adherence to HIV treatment services

[7] An example of a Comprehensive Assessment is located in Appendix V

- Oral health care
- Home health care
- Medical nutritional services
- Mental health services
- Substance abuse treatment

4.3 Comprehensive Assessment – Secondary Activity Areas

The current status of a client's self-reported psychosocial support and HIV risk behavior is important information for developing ISP goals.

Case managers must assess the client's history and current needs in these secondary activity areas:

- Housing
- Medical transportation
- Food/meal programs
- Linguistic services
- Legal
    - HIV-related
    - Criminal history
    - Immigration
- Physical mobility/activities of daily living
- Employment/re-employment
- Social/emotional support
- Knowledge of HIV disease
- Knowledge of prevention/transmission of HIV and STI
- Tobacco use
- Affected family/household members

4.4 Reassessment

Reassessing a client allows the case manager to identify new issues and needs as well as evaluating the client's strengths and progress towards self-sufficiency. Case managers use this information to update the ISP and establish new goals.

- Case managers must do an interim reassessment utilizing the ISP every 12 months
- Case managers must complete a reassessment if there is a significant (more than 50%) change in need

4.5 Reassessment of Eligibility

Case managers must document and verify residency, income and health coverage status every 6 months per Health Resource and Service Administration (HRSA) guidelines. This reassessment of eligibility must be in compliance with eligibility policy guidance, Standard 1.1.[8]

[8] An example of a 6 Month Eligibility Reassessment form is located in Appendix VI

Standard 4.0 Comprehensive Assessment and Reassessment	
STANDARD	**MEASURE**
Case Manager must:	
4.1 Timeline	
a. Initiate the comprehensive assessment within 2 business days of intake	a. Documented in client chart or EMR
b. Complete the comprehensive assessment within 30 days of intake	b. Documented in client chart or EMR
c. Complete a new comprehensive assessment every 5 years	c. Documented in client chart or EMR
4.2 Comprehensive Assessment – Primary Activity Areas	
a. Assess the client's history and current needs in primary activity areas	a. Documented in client chart or EMR
b. Sign and date the comprehensive assessment	b. Documented in client chart or EMR
4.3 Comprehensive Assessment – Secondary Activity Areas	
a. Assess the client's history and current needs in secondary activity area	a. Documented in client chart or EMR
b. Sign and date the comprehensive assessment	b. Documented in client chart of EMR
4.4 Reassessment	
a. Reassess clients at least once every 12 months	a. Documented in client chart or EMR
b. Complete a reassessment if there is a significant (more than 50%) change in need	b. Documented in client chart or EMR
c. Sign and date the reassessment	c. Documented in client chart or EMR
4.5 Reassessment of Eligibility	
a. Verify residency every 6 months	a. Documented in client chart or EMR
b. Verify income every 6 months	b. Documented in client chart or EMR
c. Verify health coverage status every 6 months	c. Documented in client chart or EMR

This page left blank intentionally

Standard 5.0 Individual Service Plan (ISP)

The objective of the ISP standard is to ensure that case managers:

- Complete ISP within 2 weeks of initiation
- Create ISP based on comprehensive assessment (Standard 4.0)
- Develop an action plan to meet client's needs and goals
- Incorporate HIV Case Management performance indicators into MCM services

Once the case manager has completed and signed the comprehensive assessment, the case manager develops the client's ISP[9]. The ISP is a set of goals and activities that help clients access and maintain services, particularly primary medical care, gain or maintain medication adherence, and move towards self-sufficiency. The specific goals in an ISP must relate directly to the assessment information.

Case managers must document that all updates to the ISP are communicated to and agreed to by the client. Both the case manager and client must sign and date the ISP; however agencies using EMRs may use electronic signatures for case managers and document client agreement in lieu of client signature. While the case manager does not need to print the ISP, the client's paper chart must identify where the ISP is stored. Additionally the client must be offered a copy of his or her ISP and this should be documented in the client's paper chart.

5.1 Timeline

Case managers must:

- Develop initial ISP within 2 business days of completing comprehensive assessment
- Complete and sign ISP within 2 weeks of initiating ISP
- Reassess and renew ISP at least every 12 months
- Offer a copy of ISP to client on date of completion

5.2 Link to Assessment

The ISP must include service goals and activities that specifically link to the client's needs identified during the initial comprehensive assessment and subsequent reassessments.

5.3 ISP Content

Case managers must develop an ISP that addresses primary (Standard 4.2) and secondary activity areas (Standard 4.3) by listing and identifying:

- Client needs or gaps in services
- Client goals to address needs/gaps in services
- Referrals made or actions taken to address gaps
- Person responsible for action steps in ISP

[9] An example of a ISP is located in Appendix VII

This page left blank intentionally

Standard 5.0 Individual Service Plan (ISP)	
STANDARD	**MEASURE**
Case Manager must:	
5.1 Timeline	
a. Initiate ISP within 2 business days of completing comprehensive assessment	a. Documented in client chart or EMR
b. Complete ISP within 2 weeks of initiation	b. Documented in client chart or EMR
c. Sign and date ISP	c. Signed and dated ISP in client chart or in EMR
d. Offer copy to client	d. Documented in client chart or EMR that copy of ISP was offered/given to client
e. Reassess and renews ISP at least every 12 months	e. Copy of updated ISP in client chart or EMR
f. Sign and date revised ISP	f. Signed and dated revised ISP in client chart or in EMR
g. Offer copy of revised ISP to client	g. Documented in client chart or EMR that copy of revised ISP was offered/given to client on dates of ISP completion
5.2 Link to Assessment	
a. Develop initial ISP from the comprehensive assessment	a. ISP goals address needs identified in the comprehensive assessment as documented in the client's chart
5.3 ISP Content	
a. ISP addresses primary and secondary activity areas by listing and identifying • Client needs or gaps in services • Client goals to address needs/gaps in services • Referrals made or actions taken to address gaps • Person responsible for action steps in ISP	a. Copy of ISP with appropriate content in client chart signed and dated by client and case manager

This page left blank intentionally

Standard 6.0 Service Plan Implementation

The objective of the service plan implementation standard is to ensure that case managers:

- Complete progress notes to document client progress toward ISP goals and objectives
- Coordinate care with appropriate collateral partners
- Ensure readiness for, and adherence to, HIV/AIDS treatment

Service plan implementation is an on-going process that ensures services are consistent with the ISP and that clients in medical case management are making progress on accessing services to meet their needs and goals.

6.1 Progress Notes

Progress notes ensure the most up to date information is available in the client's file and provide documentation that the case manager has followed proper procedures, rules, regulations, and necessary guidelines when providing services. By documenting each contact with a client, case managers are able to track what services the client has received and still needs to access. If billing Title XIX, case managers must complete a progress note for every billing date.

In completing progress notes, case managers must follow these guidelines:

- Document chronologically
- Focus on the goals of the ISP including:
    - Reason for interaction with client
    - Client needs and action of the case manager to address these needs
    - Plan for follow up
- Ensure documentation is clear
    - Write notes legibly and in the third person (e.g. "case manager met with client and discussed options for medication coverage")
    - When necessary, place a line through an error and initial it
- Be objective in documentation
- Record all interactions with and on behalf of client
- Sign and date within 5 business days of encounter or visit with, or on behalf of, the client
    - Agencies using electronic medical records may use electronic signatures. While the case manager does not need to print the progress notes, the client's paper chart must contain a document that indicates where the information is stored.

6.2 Coordination of Services

A critical role of the case manager is the coordination of communication and services within a clinic, agency or care system. Care coordination includes case conferences, access to client records, or the use of written communication to indicate a client's utilization of services.

Case managers must ensure the coordination of services by:

- Identifying staff or service providers with whom the client may be working
- Acting as a liaison between clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision

- Facilitating the scheduling of appointments, transportation, or transfer of information when a client is unable to do so him or herself
- Assisting clients to increase self-sufficiency so that clients can independently:
    - Navigate the care system
    - Communicate directly with providers
    - Schedule appointments

6.3 Treatment Adherence

Among the most important goals of medical case management is the ability of the case manager to:

- Coordinate and support medical treatment adherence
- Assess ART treatment readiness
- Provide support for ART treatment adherence

Case managers have a responsibility to directly provide or link their clients to treatment adherence services.[10] An assessment of adherence education and support needs should begin as soon as a client enters medical case management and continues as long as a client remains in medical case management. Treatment adherence support is an on-going process that changes as the client's needs, goals, and medical condition change. The goal of any treatment adherence intervention is to provide a client with necessary skills, information, and support to follow mutually agreed upon and evidence-based recommendations of healthcare professionals to achieve optimal health. This includes:

- Taking all medications as prescribed
- Making and keeping appointments
- Adapting to therapeutic lifestyle changes, as necessary, to gain or maintain engagement in care and adherence to medications

6.4 Prevention

Case managers have ongoing relationships with clients whose HIV and sexually transmitted infections (STI) prevention needs vary throughout the course of their lives. Evidence-based HIV/STI prevention services help clients protect themselves and others in high-risk situations and environments. HIV/STI prevention services should be coordinated with HIV care services to help clients reduce their risk of transmitting HIV, STI or blood borne diseases. This also helps clients reduce their risk of acquiring resistant strains of HIV, STI or blood borne diseases.

At least once every 12 months, case managers must provide accurate information about HIV/STI transmission risks and promote evidence-based HIV/STI prevention activities. This discussion must be documented in either a progress note or on the effected ISP.

During the assessment and annual reassessment, case managers must assess a client's current HIV/STI transmission risk. Client needs identified during this process allows medical case managers, as appropriate, to:

- Explore clients' readiness to engage with available HIV/STI prevention resources, as necessary
- Refer clients to available HIV/STI prevention and treatment services

[10] An example of Adherence forms are located in Appendix VIII

- Assist clients to coordinate their participation in HIV/STI prevention services with their medical care
- Assist clients to obtain medical and social support services that reinforce their efforts to reduce HIV/STI transmission
- Document clients' progress toward achieving their acknowledged HIV/STI prevention needs

This page left blank intentionally

Standard 6.0 Service Plan Implementation	
STANDARD	**MEASURE**
Case Manager must:	
6.1 Progress Notes	
a. Maintain progress notes of all communication between provider and client	a. Documented in client chart or EMR
b. Document service provided	b. Documented in client chart or EMR
c. Write progress notes that indicate referrals that link clients to needed services	c. Documented in client chart or EMR
d. Date and sign progress notes	d. Documented in client chart or EMR
e. Place progress notes in chart in chronological order	e. Documented in client chart or EMR
6.2 Coordination of Services	
a. Identify staff or service providers with whom the client may be working	a. Documented in client chart or EMR
b. Act as a liaison among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision	b. Documented in client chart or EMR
c. Facilitate the scheduling of appointments, transportation, transfer of information	c. Documented in client chart or EMR
6.3 Treatment Adherence	
a. Assess and monitor access to and retention in medical care	a. Documented in client chart or EMR that client has seen a medical provider in the last six months or effort has been made to engage client in primary care
b. Assess and monitor access to HIV medications	b. Documented in client chart or EMR that client has prescription coverage
c. Assess and monitor medication adherence	c. Documentation of assessment of formal treatment adherence at least every 12 months
d. Assess and monitor treatment adherence	d. Documented in client chart or EMR that client is making and keeping appointments
e. Monitor laboratory results	e. Documentation in client chart or EMR of client's CD4 and Viral Load in the last 12 month as per medical provider report
6.4 Prevention	
a. Provide accurate information about HIV/STI transmission risks and promote evidence-based HIV/STI prevention activities	a. Documentation in client chart or EMR that transmission risks and prevention activities discussed in the last 12 months.

This page left blank intentionally

Standard 7.0 Transition and Discharge

The objective of the transition and discharge standard is to ensure that case managers:

- Make a clear distinction between active, inactive, brief and discharged clients
- Specify the reasons for transition or discharge
- When possible develop a plan for clients who transition or discharge

Case managers must use a systematic process to transition or discharge clients from case management services to attempt to provide continuity of care and case management services.

7.1 Discharge

Case managers must document the reason(s) for transitioning or discharging a client from case management services in a "transition/discharge summary". If the client does not agree with the reason for discharge, the case manager should refer him or her to the provider agency's grievance procedure (Standard 1).[11]

A case manager may close a case for any of the following reasons:

- Client request
- Transition to another program for case management services
- Client no longer meets the eligibility requirements
- Completion of ISP
- Violation of agency policies and procedures
- Relocation
- Incarceration
- Disengaged from care for twelve months
- Deceased

By default, client's charts will be considered closed after a period of 12 months of no contact.[12] The case management process as described in these standards does not have to be repeated for an inactive client who returns to the agency for services within a 12 month period of being placed on inactive status. However, a minimum evaluation and update of the broad assessment areas should be performed and documented in the client record to determine new needs, service plan additions and appropriate service level.

7.2 Transition or Discharge Summary

Medical Case Managers must document a transition/discharge summary in a client's chart for those who no longer want or need services from the case manager. Summary must include:

- Reason for transition or discharge
- Efforts to provide continuity of care and case management services

[11] An example of a Complaint/Grievance Report is located in Appendix IX
[12] An example of a Case Closure form is located in Appendix X

If the client consents, a case manager should provide the client's new case manager with the most recent assessment and updated ISP to help ease the transition. All communication with the new case manager should be documented in the client's progress notes.

Agencies or case managers should maintain a list of medical case management resources that are available to the client for referral purposes.

Standard 7.0 Transition and Discharge	
STANDARD	**MEASURE**
Case Manager must:	
7.1 Reason for Discharge	
a. Reason for transition/discharge documented	a. Documented in client chart or EMR
7.2 Transfer/Discharge Summary	
a. A summary is documented in the client's chart	a. Transition/discharge summary is in client chart or EMR

This page left blank intentionally

Appendices

The forms located in the appendices are simply examples of forms that agencies can utilize in their programs. Agencies will not be penalized for not utilizing them as long as their form covers all items specified in the standards.

For examples of policies please contact Neil Good at neil.good@doh.wa.gov or 360-236-3457.

This page left blank intentionally

Appendix I

Release of Information (ROI)

Example #	Agency
1	Clark County Public Health
2	Evergreen AIDS Foundation

This page left blank intentionally

Your Agency's Name

Case Management Program

Agency Street Address, City, State Zip
Phone & Fax Number

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: _____ DOB: _____ (mm/dd/year) Phone # _____

I authorize an exchange of information between

REQUIRED FOR TITLE II CLIENTS - Washington State Department of Health for Contract Monitoring & Quality Assurance, Billing and Chart Reviews

Name of Provider/Clinic/Organization	Street Address	City, State, Zip
Name of Provider/Clinic/Organization	Street Address	City, State, Zip
Name of Provider/Clinic/Organization	Street Address	City, State, Zip
Name of Provider/Clinic/Organization	Street Address	City, State, Zip
Name of Provider/Clinic/Organization	Street Address	City, State, Zip
Name of Provider/Clinic/Organization	Street Address	City, State, Zip
Name of Provider/Clinic/Organization	Street Address	City, State, Zip
Name of Provider/Clinic/Organization	Street Address	City, State, Zip

and the Your Agency's Name

I AUTHORIZE the following information to be disclosed (please initial all that apply):

_____ Entire Record	_____ Psychiatric/Mental Health	_____ Housing
_____ HIV Record	_____ Alcohol/Substance Use	_____ TB
_____ STD Record	_____ Billing Records	_____ Other

REASON for disclosure of health information (please initial):

_____ At my request	_____ Job	_____ Housing
_____ Continuing care	_____ School	_____ Other
_____ Legal	_____ Insurance	

EXPIRATION of this Authorization (please initial one):

_____ 1 year after signature date _____ on this date: _____

_____ When this event happens: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.*
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected by ***Your Agency's Name***
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

Client Signature (Parent or Legal Representative, if applicable) **Relationship/Authority** **Date (mm/dd/year)**

*I wish to withdraw this authorization: _____ **Date (mm/dd/year)**

Witness Signature: _____

This form is compliments of Clark County Public Health

This page left blank intentionally

AUTHORIZATION TO REPRESENT AND TO OBTAIN OR RELEASE INFORMATION

I, _____ _____ _____
Name of Client Date of Birth (mm/dd/year) Social Security #

authorize **Your Agency's Name** to represent me to the following parties in an effort access and coordinate needed services or assistance: **(Client is to initial each entry)**

_____ Department of Social & Health Services _____ _____

_____ Social Security Administration _____ _____

_____ Physician (name) _____ _____ _____

_____ Early Intervention Program _____ _____

_____ Department of Health _____ _____

_____ Evergreen Health Insurance Program _____ _____

This release includes, but is not limited to, authority to discuss and obtain information/forms concerning:

☐ HIV Status	☐ Social Work Documents	☐ Ensuring Continuity of Care
☐ Substance Use/Treatment	☐ Discharge Information	☐ _____
☐ Psychosocial Assessments	☐ Medical Records	☐ _____
☐ Treatment Plans	☐ Financial Information	☐ _____
☐ Mental Health	☐ Insurance Benefits	☐ _____

If information to be obtained or released to any particular person or entity is to be otherwise limited, please specify:

_____

Method of Release: ☐ Fax ☐ Written ☐ Verbal ☐ Electronic

I understand that my records may be protected from disclosure without my written consent under federal and state law. I also understand that I may revoke this consent in writing at any time. Such revocation will not apply to any materials released previously. A photocopy of this authorization shall be as valid as the original.

I authorize ***Your Agency's Name*** to obtain/release all information concerning the above matters to/from the above listed sources I understand that this information is necessary to obtain the best results in the work done on my behalf. I have been told that the case manager/advocate may record personal information about me to help him/her provide appropriate services to me. I hereby authorize him/her to do so, provided the information be kept confidential and not be disclosed except to persons or agencies directly involved and those listed above. Notwithstanding the above, I authorize ***Your Agency's Name*** to provide access to records and information to any state, federal or other funding agency, the State Auditor, and to any other person authorized by law, in order to monitor and evaluate performance, compliance, and quality assurance or as required by law, provided that all identifying client information is safeguarded to the fullest extent practicable. I also understand that because much of the funding for ***Your Agency's Name*** comes from state and federal sources, ***Your Agency's Name*** is required to provide demographic information to such sources. Any information provided is disclosed by a confidential identifier, not by name.

This consent will **expire** on termination services or one (1) year from ***enter the date ROI is filled out,*** whichever comes first. At that time, the authorization must be renewed for this agreement to remain valid. I understand that a failure to sign or renew this authorization may result in the loss or disruption of services, assistance, rights, claims or other such benefits.

To insure continuity of service, ***Your Agency's Name*** may release contact information and/or documents establishing eligibility for services including proof of residency, HIV verification, insurance coverage and income to any new service provider selected to provide medical case management services in your country of residence or where you receive such services through the Ryan White program. Where time is of the essence and reasonable efforts to contact the client have failed, ***Your Agency's Name*** may in its discretion, also release other information to the new provider, but only to the limited extent necessary to protect the client's health of well-being.

_____ _____
Client/Representative Signature Date

This form is compliments of Evergreen AIDS Foundation

This page left blank intentionally

Appendix II

Consent for Services form

Example #	Agency
1	Clark County Public Health
2	Evergreen AIDS Foundation

This page left blank intentionally

CONSENT FOR SERVICES

I request services from a Case Manager at ***Your Agency Name***. I agree to participate in the planning, implementation and ongoing meetings necessary to develop services to address my specific needs.

Client Records

I understand that the HIV/AIDS Case Management Program keeps records of services provided to me. This record may contain important health information including sexually transmitted disease and HIV/AIDS diagnoses. This information is confidential and protected by law. Information from my record may not be disclosed to others without my written permission, except under the following circumstances: when you tell us that you will harm yourself, another person, or you will harm or have harmed a child. Additionally, program funders may have access to these records when auditing for completeness and accuracy.

I may ask to see, copy, and/or correct my record. There may be a reasonable charge for me to obtain copies of my record.

_____ *(initial)* I understand the above information and agree to participate in case management services. I understand any questions I have can be answered before I sign.

OR

_____ *(initial)* I understand I may receive services for up to 30 days without signing this consent. If I choose not to sign this consent within 30 days my case will be closed.

_____
Client Signature

_____
Witness Signature

_____
Date

_____
Date

This form is compliments of Clark County Public Health

This page left blank intentionally

Acknowledgement and Consent to Services

I acknowledge that I have received copies of the following documents and had an opportunity to review them and to have any questions I have answered by my case manager:

- ☐ Eligibility for Services
- ☐ Free Choice of Provider Policy
- ☐ Client Rights and Responsibilities
- ☐ Confidentiality Policy
- ☐ Language Policy
- ☐ Client Grievance Policy and Procedure
- ☐ Case Closure Policy

I consent to receive services, including case management services at ***Your Agency Name.*** I understand that I may withdraw from services at any time and that my continued cooperation is important in maintaining my ability to receive services.

Client Signature _____ Date (mm/dd/year) _____

This form is compliments of Evergreen AIDS Foundation

This page left blank intentionally

Appendix III

Client Intake Form

Example #	Agency
1	Washington State Department of Health (DOH)

This page left blank intentionally

Washington State Department of Health

CLIENT INTAKE FORM

* ***Please fill in all dates in the following format: mm/dd/year***

Indentifying Information

Date of Initial Client Contact:	Date Intake Started:	Date Intake Completed:	Client ID#:

Last Name:	First Name:	Middle Name:	Preferred Name:

Birthdate	Age	Social Security #

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Partnered ☐ Divorced ☐ Widowed

What gender do you identify with?

☐ Male ☐ Female ☐ Transgender MtF ☐ Transgender FtM ☐ Other

Ethnicity

☐ Hispanic ☐ Non-Hispanic

Race

☐ Alaskan / Native American ☐ Asian ☐ Caucasian / White ☐ African American / Black ☐ Hawaiian / Pacific Islander
☐ More than one race ☐ Unknown ☐ Other (please specify):

Cultural / Linguistic Need

English Language Ability: ☐ Good ☐ Fair ☐ Poor ☐ Not Spoken

What language(s) do you speak?

Translator service needed? ☐ Yes ☐ No

Do you need written materials translated? ☐ Yes ☐ No

Hearing Impaired? ☐ Yes ☐ No

Need sign interpreter? ☐ Yes ☐ No

Reading Difficulty? ☐ Yes ☐ No

Contact Information

Street:	Apt. #	City:

State:	Zip:	County:	Okay to Send Mail? ☐ Yes ☐ No

Mailing Address (If different from above address):	Apt. #	City:

State:	Zip:	County:	Okay to Send Mail? ☐ Yes ☐ No

Phone # (with area code):	**May we contact you at this number or leave a message? ☐ Yes ☐ No**

Alternate Phone # (with area code):	**May we contact you at this number or leave a message? ☐ Yes ☐ No**

Email Address:	**Okay to send email to this address? ☐ Yes ☐ No**

Emergency Contact Information

Contact Name (Last, First M.I.)	Relationship	Phone#:
Street:	Apt. #	City:
State: / Zip:	Is this person aware of your HIV status? ☐ Yes ☐ No	
Alternate Contact Name (Last, First M.I.)	Relationship	Phone#:
Street:	Apt. #	City:
State: / Zip:	Is this person aware of your HIV status? ☐ Yes ☐ No	

Veteran Status

Are you a Veteran? ☐ Yes ☐ No	Service Dates	Type of discharge?	Service connected disability? ☐ Yes ☐ No

Please describe your service connected disability?

Medical Information

Referral Source:	Date tested HIV positive:	Date of AIDS diagnosis:

How do you think you were infected?

☐ Male to Male sex ☐ Heterosexual sex ☐ Injection drug user ☐ Perinatal transmission ☐ Receipt of transfusion ☐ Uknown ☐ Other:

Primary Care Physician:	Facility:	Phone #:
Specialist Physician:	Facility:	Phone #:

Insurance Benefits

Are you on: ☐ Medicaid ☐ Medicare ☐ EIP ☐ EHIP ☐ Private Insurance ☐ VA ☐ No Insurance

DSHS Case #:	DSHS Case Manager:	PIC #:
Medicare #:	Name of Insurance Company:	
☐ Part A ☐ Part B ☐ Part D	☐ Individual Policy ☐ Group Policy	
Group #:	Individual #:	Phone #:

Additional Insurance Information:

Housing / Living Situation

Housing Type	Do you live in subsidized housing?	# of persons in household:
☐ Permanent ☐ Homeless ☐ Temporary	☐ Yes ☐ No	

Please indicate the total number of persons in your family for whom you are legally responsible:

_____ Self _____ Spouse _____ Children under 18 _____ Children over 18

Total # of dependents

Employment / Financial

Are you currently employed?	Are you receiving disability income?	Disability based on:
☐ Yes ☐ No	☐ Yes ☐ No	☐ HIV ☐ Drug/Alcohol ☐ Mental Health ☐ Other Medical

Monthly income received

☐ GAU: $ _____ ☐ SSI: $ _____ ☐ SDI: $ _____ ☐ VA: $ _____ ☐ Private: $ _____

☐ Child Support: $ _____ ☐ Food Stamps: $ _____ ☐ Other Income: $ _____

Total Monthly Income
$ _____

_____ _____

Client Signature Date

_____ _____

Case Manager Signature Date

This page left blank intentionally

Appendix IV

HIV/AIDS Verification form

Example #	Agency
1	Clallam County Department of Health & Human Services
2	Clark County Public Health
3	Evergreen AIDS Foundation

This page left blank intentionally

YOUR AGENCY NAME

HIV/AIDS CASE MANAGER

Street Address

City, State, Zip

Phone Number

Client HIV/AIDS Verification

Client Name: _____ DOB: _____ mm/dd/year

Medical Information to be completed by a Medical Provider

Date of Antibody test: _____ mm/dd/year

Current HIV status: _____ Asymptomatic

_____ HIV related condition and illness

Please list any HIV related condition and illnesses:

_____

_____

_____

Is client disabled by HIV condition? ____ YES ____ NO

Most recent CD4 laboratory results:

		Month/Year
Absolute T4 (CD4)	_____ MM	_____
T4 (CD4) Percent	_____ %	_____
Viral Load Count	_____	_____

Health Care Provider/Clinic: _____

Provider Name: _____

Phone Number: _____ Fax Number: _____

Office Address: _____

City: _____ State: _____ Zip: _____

_____ _____

Physician's Signature Date (mm/dd/year)

This form is compliments of Clallam County Department of Health & Human Services

This page left blank intentionally

YOUR AGENCY NAME OR LOGO

HIV/AIDS CASE MANAGEMENT

Street Address, City, State Zip, Phone # and Fax #

Dear Dr. _____ Date: _____

Your patient, listed below, is a client of the **Your Agency Name** case management program. In order to meet state requirements for case management services, we need medical confirmation of your patient's HIV status. Please complete the following information and return to us by mail at: **Your Agency's Address** or you may fax it to **Your Agency's Fax #**.

Please sign and date the bottom of this form.

Thank you!

_____

Case Manager Name

Patient:		**DOB:**
Latest CD4 Count:	**CD4%**	**Viral Load:**
Date of results:	**Date of last Doctor visit:**	
This patient is HIV+:	**AIDS diagnosed:**	
Opportunistic infections:		
Current medications:		
Physician's signature:		**Date:**

This form is compliments of Clark County Public Health

This page left blank intentionally

HIV/AIDS Verification

Client Name: _____

DOB: _____ (mm/dd/year) SS#: ___ – ___ – ____

Medical Information to be Completed by Medical Provider

Date of Antibody Test: _____ (mm/dd/year) Result: ☐ Positive/Reactive (Confirmed) ☐ Negative/Indeterminate

Current HIV Status: ☐ Asymptomatic ☐ HIV-related conditions & illnesses

Please list any HIV-related conditions and illnesses:

_____

_____

_____

Is client disabled by their HIV condition? ☐ Yes ☐ No

Most recent laboratory results:

		Month / Year
Absolute T4 (CD4)	_____ MM	_____
T4 (CD4) Percent	_____ %	_____
Viral Load Count	_____	_____

Health Care Clinic / Medical Practice: _____

Provider Name: _____ Phone #: _____

Office Address: _____

Provider signature: _____ **Date:** _____ (mm/dd/year)

I consent for the above provider to verify my HIV/AIDS status and to provide the requested medical information to **Your Agency Name** for the purpose of enrolling in case management services.

Client signature: _____ **Date:** _____ (mm/dd/year)

This form is compliments of Evergreen AIDS Foundation

This page left blank intentionally

Appendix V

Homeless Client Statement

Example #	Agency
1	Washington State Department of Health (DOH)

This page left blank intentionally

Homeless Client Statement

I, _____, _____certify that:
Client Name Date of Birth

Please initial any applicable items:

____ Last night I spent the night in one of the following places:

____ Park
____ Abandoned Building
____ Car
____ Street /Sidewalk
____ Shelter
____ Other (Please describe): _____
_____
_____

____ In the following city: _____

Additional Information:

_____

_____

_____

(Please continue on back if necessary)

No Income Statement

If you (or you and your family) do not have any income, tell us how you support yourself:

I understand that if I give false information about not having any income, I may lose benefits and/or have to pay back for services I received.

Client Signature: _____ Date: _____

This page left blank intentionally

Appendix VI

Comprehensive Assessment

Example #	Agency
1	Washington State Department of Health (DOH)

This page left blank intentionally

CLIENT COMPREHENSIVE ASSESSMENT

* ***Please fill in all dates in the following format: mm/dd/year***

Indentifying Information

Date Intake Completed	Date Assessment Started	Date Assessment Completed	Client #

Last Name:	First Name:	Middle Name:	Preferred Name:

Referral Source and Reason

Referral Source:	Date of referral:

Reason for referral and presenting issue:

Clinical / Medical Information

Diagnosis confirmed by:			Date of confirmation:
Date tested HIV positive:	Location:	Current T-Cell count:	Current viral load:
Date of AIDS diagnosis:	AIDS diagnosis based on:		Reported? ☐ Yes ☐ No

Hospitalized in the last year? ☐ Yes ☐ No	If yes, where?	Admin date:	Discharge date:

Reason for hospitalization:

General state of health (Client's assessment): ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Failing

Current physical symptoms:

Height:	Weight:	Significant recent changes in health status?

Current cognitive symptoms: (Memory loss, forgetfulness, dementia)

Allergies: ☐ Pets ☐ Foods ☐ Medications	Describe allergies:

Dentist:	Date of last visit:

Significant dental problems? ☐ Yes ☐ No	If yes please describe:

Other health conditions:

Clinical / Medical Information Continued

Women Only	Are you on birth control? ☐ Yes ☐ No	Are you breastfeeding? ☐ Yes ☐ No	Are you pregnant? ☐ Yes ☐ No	If yes, due date:	Are you receiving prenatal care? ☐ Yes ☐ No
	When was your last PAP?		Results: ☐ Normal ☐ Abnormal		

Treatment / Medication Adherence

Are you currently taking HIV medications?

☐ Yes, please list all meds and dosages ☐ No

HIV Medication Name	# of Pills / Dosage per day / Time of Day

☐ Not recommended by provider at this time.

☐ Does not want to take HIV meds. Please explain:

How many pills did you miss taking last week? # of doses taken late:

On average, how many days per week do you miss at least one dose of your HIV medications?

If you have difficulty with your medications, what would help you take them as prescribed?

What percent of meds do you take as prescribed? %

List all the pharmacies that you use:

Do you ever run out of pills before you get your next refill? ☐ Yes ☐ No

What is your understanding of how your medication(s) works? ☐ Thorough ☐ Basic ☐ Limited

Have you ever stopped taking your meds without your doctor's permission/knowledge? ☐ Yes ☐ No ☐ N/A

Is your doctor aware of adherence problems? ☐ Yes ☐ No ☐ N/A

Do you have a drug list? ☐ Yes ☐ No

Do you provide a drug list to all medical providers? ☐ Yes ☐ No

Barriers to Drug Adherence (Check all that apply)

- ☐ Too many pills/bottles
- ☐ Misplaced/lost/left somewhere else
- ☐ Change in my routine
- ☐ Lack of regular schedule
- ☐ Away from home
- ☐ Lack of privacy
- ☐ Undisclosed HIV status
- ☐ Lack of stable housing
- ☐ Work outside the home
- ☐ Too busy
- ☐ Taste of medication
- ☐ Reminder of disease
- ☐ Feel too sick to take meds
- ☐ Don't feel sick, why take meds?
- ☐ Forgot
- ☐ Can't afford meds
- ☐ Asleep
- ☐ Depression/mental health
- ☐ Alcohol/substance use/abuse
- ☐ Complex medication regimen
- ☐ Lack of information
- ☐ Lack of motivation
- ☐ Care giving responsibilities
- ☐ Lack of social support
- ☐ Difficulty getting refills
- ☐ Didn't receive/order meds on time
- ☐ Doubts medication effectiveness
- ☐ Needs assistance with ADLs
- ☐ AIDS Dementia
- ☐ Other (specify)
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Comments regarding medication adherence:

Basic Necessities / Activities of Daily Living (ADL)

Are you able to meet your ADLs? ☐ Yes ☐ No	Comments:

Do you need assistance with chores? ☐ Yes ☐ No	Do you require assistance with hygiene/clothing needs? ☐ Yes ☐ No	Do you need assistance meeting food/nutritional needs? ☐ Yes ☐ No	Are you on food stamps? ☐ Yes ☐ No

If yes to food stamps how much: $	Do you need home food delivery? ☐ Yes ☐ No	If so, do you prefer: ☐ Groceries ☐ Pre-made meals

Nutrition

Have you gained or lost more than 10 pounds in the last 6 months? ☐ Yes ☐ No How much?

If yes, please explain:

Have there been changes in your eating habits? ☐ Yes ☐ No

If yes, please explain:

Please describe needs/strengths in your daily activities:

Mental Health / Psychosocial

How have you been coping with HIV/AIDS?

Have you ever been in treatment for mental health issues? (outpatient tx or therapy) ☐ Yes ☐ No	When?	Where?

What was the focus of your treatment?

Have you ever taken medications for psychiatric reasons? ☐ Yes ☐ No	Current psychiatric medications:	Past psychiatric medications:

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No	When?	Where?

Have you ever had thoughts of suicide? ☐ Yes ☐ No	If yes, how recent?
Have you ever attempted suicide? ☐ Yes ☐ No	Describe in detail?
Do you have a plan for suicide? ☐ Yes ☐ No	Describe plan?

Additional mental health information:

Substance / Alcohol Use

People deal with the stress of HIV / AIDS in many ways. Some people isolate, some sleep and some people find themselves turning to alcohol or drugs to cope. Have you found yourself using these sorts of things to get by? ☐ Yes ☐ No

If yes, please describe:

Substance / Alcohol Use Continued

Current Use	Amount	Frequency (Daily/Weekly/Monthly)	Duration (<1yr, 1-2 yr, >2yrs)	Last Use (<1mo, 1-6mos, 6mos-2yrs, >2yrs)
Tobacco / Nicotine				
Alcohol				
Marijuana				
Cocaine/Crack				
Heroin				
Speed/Meth				
Hallucinogens				
Prescription Drugs				
Other				

Are you currently injecting drugs?	Have you ever injected drugs?	Do you sometimes share needles?	Are you aware of the needle exchange
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Describe history of substance abuse, if applicable: (drug of choice, age started, how long since last use, triggers, etc.)

Have you had previous substance abuse treatment?	If yes,	Dates of most recent treatment	Where did you receive treatment?
☐ Yes ☐ No	☐ Inpatient ☐ Outpatient		

Describe treatment experience:

Do you identify drugs as a problem?	Do you identify alcohol as a problem?	Do you identify tobacco as a problem?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does your significant other or family members identify drugs / alcohol / tobacco as a problem for you? ☐ Yes ☐ No

Are you considering quitting tobacco in the next 30 days? ☐ Yes ☐ No

If yes - Would you like information or resources to help you quit? ☐ Yes, referral given to quit line ☐ No

If no – Would you like information or resources to learn more about quitting options and the importance of quitting? ☐ Yes ☐ No

What support would you like from me? (follow up at certain time, quitting as part of the ISP?, etc.)

Housing / Living Situation

Current living situation (check all that apply):

☐ Own House ☐ Rental House ☐ Apartment ☐ With Family ☐ With Friends
☐ Homeless ☐ Transitional ☐ Shelter ☐ Care Facility ☐ Hospice
☐ Live Alone ☐ Live with children ☐ On streets/camping ☐ Other:

Describe current living situation: (stability, safety, affordability)

Persons living in household:

Name	Relationship to Client	DOB (minors)	Aware of HIV Status?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Do you have dependent children who do not live with you? ☐ Yes, number: ☐ ☐ No

Estimated Monthly Housing / Utility Costs:

$ _____ Rent/Mortgage $ _____ Electric $ _____ Water/Sewer $ _____ Gas $ _____ Cable

$ _____ Phone $ _____ Garbage $ _____ Other $ _____ Other Total Costs: $

Do you receive a subsidy?
☐ None ☐ HUD/Section 8 ☐ HOPWA ☐ Other:

Have you applied for low-income housing?
☐ Yes ☐ No

Additional housing comments:

Support System

Describe your support system:

Are your parents still living? ☐ Yes ☐ No	Are they aware of your HIV status? ☐ Yes ☐ No	Where do your parents live? (city & state)
Do you have siblings ☐ Yes ☐ No	Are they aware of your HIV status? ☐ Yes ☐ No	Where do your siblings live? (city & state)

How often do you have contact with your parents and/or siblings?

Are your parents/siblings supportive? (please describe)

Do you have a partner/spouse? ☐ Yes ☐ No	Is your partner/spouse aware of your HIV status? ☐ Yes ☐ No	Is your partner/spouse supportive? ☐ Yes ☐ No
Do you have friends? ☐ Yes ☐ No	Are your friends aware of your HIV status? ☐ Yes ☐ No	Are your friends supportive? ☐ Yes ☐ No

Support System Continued

Are you involved with a religious/spiritual community? ☐ Yes ☐ No	Describe strengths/needs from your spiritual community:

Describe your hobbies, talents, interests:

Community Resources (List agencies or organizations where you access programs & services)

Organization/Agency	Aware of HIV status?	Describe services/support provided (transportation, shelter, financial, etc.)	Signed release?

What are your barriers to accessing community resources?

Employment / Financial

Are you currently employed? ☐ Yes ☐ No	Name of Employer:	How long have you been at your current job?
If full time, how many hours per week:	If part time, how many hours per week:	If no, when were you last employed?
☐ Unemployed, looking for work: (explain)	☐ Unemployed, not looking for work: (explain)	

What is the highest grade you completed in school?

List any degrees/certificates earned: (GED/AA/BA/vocational training, etc.)

Do you have difficulty reading? ☐ Yes ☐ No	Do you have difficulty writing? ☐ Yes ☐ No	Are you interested in improving these areas? ☐ Yes ☐ No ☐ NA

Financial difficulties: ☐ Credit Cards ☐ Bankruptcy ☐ Taxes ☐ Collections ☐ Loans	Estimated debt amount:

Are you on unemployment? ☐ Yes ☐ No	Have you applied for disability income? ☐ Yes ☐ No	If yes, what type: ☐ GAU ☐ SSI ☐ SSDI ☐ Private
When did you apply?	Are you receiving disability income? ☐ Yes ☐ No	Disability based on: ☐ HIV ☐ Drug/Alcohol ☐ Mental Health ☐ Other medical

Employment / Financial Continued

Income Source	Amount	Frequency (weekly, bi-monthly, monthly, other)	Total Amount
Salary			
Spouse/Partner Salary			
Short-Term Disability			
Long-Term Disability			
SSI			
SSDI			
FIP			
VA Pension			
Child Support			
Savings/Investments			
Rental Income			
Unemployment			
Retirement Benefits			
Family Support			
Other			
Check here if you have **NO** income: ☐		**Total Amount=**	

If you checked that you have no income, please explain how you are supporting yourself:

Transportation

Do you have transportation? ☐ Yes ☐ No	If yes, please describe:

If no, what are the barriers in accessing transportation?

Do you have access to and funds for transportation? (gas, bus pass, etc.) ☐ Yes ☐ No

Would you like assistance arranging transportation? (Para transit, volunteer, etc.) ☐ Yes ☐ No

How do you normally get to appointments?

Legal Needs

Advance Directives

Have you named a power of attorney? ☐ Yes ☐ No	Name:	Relationship:	Phone:
Do you have a will? ☐ Yes ☐ No	Executor:	Relationship:	Phone:

Legal Needs Continued

Do you have a living will?	Is there a copy on file with your doctor?	Is there a copy with your family?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you do not have any of the above, would you like information on advance directives at this time? ☐ Yes ☐ No

Legal

Are you currently involved in a civil or criminal legal matter? ☐ Yes ☐ No	If yes, please describe:
Do you have a history of arrests? ☐ Yes ☐ No	If yes, please describe:
Have you ever been in jail/prison? ☐ Yes ☐ No	If yes, please describe:
Are you currently on probation/parole? ☐ Yes ☐ No	If yes, who is your probation/parole officer?
Are you a U.S. citizen? ☐ Yes ☐ No	If no, what is your immigration status?

Please explain any additional legal issues:

Cultural / Linguistic

What problems are getting in your way right now?

How do you think these problems can be resolved?

What resources do you have for resolving these problems?

Which problems would you most like assistance with right now?

Self Efficacy

Able to advocate for self?	Past history of behavior change? (cessation of smoking, drinking, risky behavior, etc.)
☐ Yes ☐ No	☐ Yes ☐ No

Explain barriers to self-advocacy:

HIV Education / Prevention

What is your understanding of HIV/AIDS treatment options and benefits? ☐ Thorough ☐ Basic ☐ Limited ☐ None

Explain:

What is your understanding of HIV transmission risks? ☐ Thorough ☐ Basic ☐ Limited ☐ None

Explain:

What is your understanding of the importance of regular medical care? ☐ Thorough ☐ Basic ☐ Limited ☐ None

Explain:

What is your understanding of CD4/viral load significance? ☐ Thorough ☐ Basic ☐ Limited ☐ None

Explain:

Are you currently sexually active? ☐ Yes ☐ No

If yes, how are you protecting yourself and your partners from infection? (risk reduction strategies)

Are you afraid you may have put someone else at risk? ☐ Yes ☐ No

Explain:

Do you disclose your HIV status to your sexual partners? ☐ Yes ☐ No

Explain:

What makes it difficult for you and your partners to practice safe behaviors?

- ☐ When I am really sexually excited
- ☐ When I am with a new partner
- ☐ When I feel bad about myself
- ☐ When my partner pressures me to not use protection
- ☐ Other:
- ☐ When I feel angry or upset
- ☐ When I am drinking and/or using drugs
- ☐ When I think there's not much risk
- ☐ When I'm not expecting to have sex

If not currently engaging in sex with partners, do you have a plan to keep you and your partners safe if you were to become sexually active? Please describe:

Do you have access to condoms and other safe sex/risk reduction supplies? ☐ Yes ☐ No

Explain:

Is there anything about safer sex practices or sexual risk that you want to know more about? ☐ Yes ☐ No

If yes, explain:

Referral Needs

Areas of need identified by the Case Manager

- ☐ Medical Case Management
- ☐ Client Advocacy/Information & Referral
- ☐ Medical Care
  - HIV Specialist
  - Dentist
  - Other
- ☐ Medication Access
  - ADAP
  - Patient Assistance Program
- ☐ Medication Adherence
- ☐ Benefits Counseling
  - SSI/SSDI
  - Medicaid/Waiver
  - Medicare
  - Food Stamps
  - FIP/WIC
  - Other
- ☐ Substance Use/Addiction Evaluation/Treatment
- ☐ Mental Health Evaluation/Treatment
- ☐ Domestic Violence
- ☐ HIV Disease Information/Education
- ☐ Counseling/Therapy
- ☐ Housing
- ☐ Transportation
- ☐ Food Pantry
- ☐ Financial Assistance/Counseling
- ☐ Support Groups
- ☐ Prevention/Risk Reduction Supplies
- ☐ CRCS (Comprehensive Risk Counseling Services)
- ☐ CTR for sex/needle sharing partners
- ☐ Employment Services
- ☐ Legal Services/Advance Directives
- ☐ GED/Continuing Education
- ☐ ESL (English as a 2nd Language)
- ☐ Child Care/Dependents/Parenting Skills, etc.
- ☐ Vocational Rehabilitation
- ☐ Home Health
- ☐ Hospice
- ☐ Durable Medical Equipment
- ☐ Skilled Nursing Facility/Immediate Care Facility

Client signed Rights and Responsibilities?	Client signed Release of Information (ROI)?
☐ Yes ☐ No	☐ Yes ☐ No

Assessment

Client meets criteria for medical case management services? ☐ Yes ☐ No

Assessment Summary:

Client Signature _____ Date _____

Case Manager Signature _____ Date _____

Appendix VII

6 Month Eligibility Reassessment form

Example #	Agency
1	Washington State Department of Health (DOH)

This page left blank intentionally

6 Month Eligibility Reassessment

* ***Please fill in all dates in the following format: mm/dd/year***

Indentifying Information

Last Name	First Name	M.I.	Client ID#:

Contact Information

Street:		Apt. #	City:
State:	Zip:	County:	Okay to Send Mail? ☐ Yes ☐ No
Mailing Address (If different from above address):		Apt. #	City:
State:	Zip:	County:	Okay to Send Mail? ☐ Yes ☐ No
Phone # (with area code):		May we contact you at this number or leave a message? ☐ Yes ☐ No	
Alternate Phone # (with area code):		May we contact you at this number or leave a message? ☐ Yes ☐ No	
Email Address:		Okay to send email to this address?	☐ Yes ☐ No

***You must provide proof of your current street address. Please choose from the following:**

- **Current Washington State drivers license or ID card**
- **Utility bill (cell phone bills are not accepted)**
- **Lease / rental / mortgage agreement**
- **Homeless Client Statement**

Insurance Benefits (Please provide copy of Insurance Card)

Are you on: ☐ Medicaid ☐ Medicare ☐ EIP ☐ EHIP ☐ Private Insurance ☐ VA ☐ No Insurance

Medicare #:	Name of Insurance Company:	
☐ Part A ☐ Part B ☐ Part D	☐ Individual Policy	☐ Group Policy
Group #:	Individual #:	Phone #:
Additional Insurance Information:		

Housing / Living Situation

Housing Type	Do you live in subsidized housing?	# of persons in household:
☐ Permanent ☐ Homeless ☐ Temporary	☐ Yes ☐ No	

Please indicate the total number of persons in your family for whom you are legally responsible:

_____ Self _____ Spouse _____ Children under 18 _____ Children over 18

Total # of dependents

Employment / Financial

Are you currently employed?	Are you receiving disability income?	Disability based on:
☐ Yes ☐ No	☐ Yes ☐ No	☐ HIV ☐ Drug/Alcohol ☐ Mental Health ☐ Other Medical

Monthly income received

☐ GAU: $ _____ ☐ SSI: $ _____ ☐ SDI: $ _____ ☐ VA: $ _____ ☐ Private: $ _____

☐ Child Support: $ _____ ☐ Food Stamps: $ _____ ☐ Other Income: $ _____

Total Monthly Income
$ _____

No Income Statement

If you (or you and your family) do not have any income, tell us how you support yourself.

I understand that if I give false information about not having any income, I may lose benefits and/or have to pay back for services I received.

Please provide one of the following to prove income:

- Pay stub
- Unemployment stub
- Monthly Benefit Statement
- Annual Benefit Statement
- Employer W-2
- Bank statements showing direct deposit amounts
- Profit and Loss statement
- Child support order
- Copy of Supplimental Security Income (SSI)
- Copy of Social Security Disability Checks (SSDI)

REQUIRED SIGNATURE AUTHORIZATION

I have read and understand the information on this form. The information provided on this form is true and complete to the best of my knowledge. I understand that if I give false or inaccurate information or fail to notify **Your Agency Name** of changes in a timely manner, I may lose benefits and/or may be required to pay them back.

_____ _____

Signature of Client Date

_____ _____

CM Signature Date

Appendix VIII

Individualized Service Plan (ISP)

Example #	Agency
1	Washington State Department of Health (DOH)
2	Washington State Department of Health (DOH)

This page left blank intentionally

Washington State Department of Health

Individualized Service Plan (ISP)

Client Name:	Client ID:	Date (mm/dd/year):

	Indicated Needs	Start Date	Completion Date	Person Responsible For Action	Activity Commitment / Goal
1	Clinical/Medical				
2	Treatment/Medication Adherence				
3	Basic Necessities/ADL				
4	Insurance Benefits				
5	Mental Health/ Psychosocial				
6	Substance/Alcohol Use				
7	Housing/Living Situation				
8	Support System				
9	Employment/Financial				
10	Transportation				
11	Legal Needs				
12	Cultural/Linguistic				
13	Self Efficacy				
14	HIV Education/ Prevention				
15	Referral Needs				
16	Other				

Comments (Additional space provided on the back of this form):

Client Signature:	Date (mm/dd/year):	Client was offered a copy of the ISP?
Case Manager Signature:	Date (mm/dd/year):	☐ Yes ☐ No

ISP Comments

Date	Notes

Washington State Department of Health

Individualized Service Plan (ISP)

Last Name:	First Name:	MI:	Client ID #:	Date (mm/dd/year):

Service / Identified Need			
1. Clinical/Medical	5. Mental Health/Psychosocial	9. Employment/Financial	13. Self-efficacy
2. Treatment/Medication Adherence	6. Substance/Alcohol Use	10. Transportation	14. HIV Education/Prevention
3. Basic Necessities/ADL	7. Housing/Living Situation	11. Legal Needs	15. Referral Needs
4. Insurance Benefits	8. Support System	12. Cultural/Linguistic	16. Other

Date mm/dd/year	Service / Identified Need	Short Term Goal / Objective	Persons Responsible for Action	Intervention / Activities / Actions	Date Review Due / Timeline	Outcome of actions / Linkages Needed

Comments (Additional space provided on the back of this form):

Client Signature:	Date (mm/dd/year):	Client was offered a copy of the ISP?
Case Manager Signature:	Date (mm/dd/year):	☐ Yes ☐ No

ISP Comments

Date	Notes

Appendix IX

Adherence forms

Example #	Agency
1	Coastal Community Action Program (CCAP)
2	Evergreen AIDS Foundation
3	Clark County Public Health

This page left blank intentionally

Medication Adherence Assessment

CLIENT	CASE MANAGER
1. Is it hard for you to take your HIV meds the way your healthcare provider told you to? ☐ **Yes** ☐ **No**	1. What makes it difficult?
2. How hard are your HIV meds to take? Very Easy | Easy | Not to Bad | Difficult | Very Difficult	2. What would make it easier?
3. If you miss a dose, when do you miss it? ☐ **Morning** ☐ **Middle of the day** ☐ **Evening** ☐ **I always take my meds**	3. How can we change this?
4. Do you ever skip a dose because your meds make you feel bad? ☐ **Yes** ☐ **No**	4. How do they make you feel?
5. Do you ever go a day without taking your meds? ☐ **Yes** ☐ **No**	5. How does that make you feel?
6. Do you ever have any side effects? If so what are they? *	6. Is there anything you are doing to help the side effects?
7. Has your energy changed since you started taking your current HIV meds? * ☐ **Yes** ☐ **No** **How:**	7. What is your activity level; What are your daily activities?
8. Are you concerned that the HIV meds you are taking now might cause any of these side effects? **Weight loss in arms, legs, buttocks or face?** ☐ **Yes** ☐ **No** **Weight gain in the upper back and neck, breast or torso?** ☐ **Yes** ☐ **No**	8. Do you notice any of the side effects? When did you start noticing?
9. If you could change one thing about your HIV treatment, what would it be? *	9. Can I share this information with your doctor?

There is additional space provided on the back of this form

Please share this information with my doctor so we can discuss my medications at my next medical appointment.

My doctor is: _____

_____ _____
Client Signature Date (mm/dd/year)

_____ _____
Case Manger Signature Date (mm/dd/year)

This form is compliments of Coastal Community Action Program (CCAP)

Date	Number	Notes

Adherence Check

Test Results:

	Count	Date	In File	Comments
CD4				
Viral Load				

Medication Adherence:

How many times in the past week have you missed taking a medication? _____

How many times in the past month have you missed taking a medication? _____

How many times since last check-in have you missed taking a medication? _____

Review Treatment Plan? _____

Review Adherence Support Tools? _____

Changes? _____

Medication Side Effects:

Questions/Comments	Response/Recommendations/Plans
1)	
2)	
3)	
4)	

Comments/Notes/Plan:

_____

_____

_____

_____

_____

Date Completed _____ CM Signature _____

This page left blank intentionally

Treatment Adherence

Client Name: _____ **Physician:** _____

Dr. Appointment	Outcome
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	

HIV Lab Results

CD4 Count: _____ **Date:** _____ **Viral Load:** _____ **Date:** _____

CD4 Count: _____ **Date:** _____ **Viral Load:** _____ **Date:** _____

CD4 Count: _____ **Date:** _____ **Viral Load:** _____ **Date:** _____

CD4 Count: _____ **Date:** _____ **Viral Load:** _____ **Date:** _____

CD4 Count: _____ **Date:** _____ **Viral Load:** _____ **Date:** _____

This form is compliments of Clark County Public Health

This page left blank intentionally

Appendix X

Complaint / Grievance Report

Example #	Agency
1	Clark County Public Health

This page left blank intentionally

Date Filed: _____

Date Resolved: _____

COMPLAINT / GRIEVANCE REPORT

Name of Client: _____

Address of Client: _____

Phone Number: _____

Name of Person Making a Complaint / Grievance: _____

Relationship to Client: _____

Name of Staff Receiving Complaint / Grievance: _____

Method of Filing: [ ] Letter [ ] Phone [ ] Interview [ ] Other (describe) _____

Details of complaint / Grievance (Cite dates and attach pertinent documentation):

Signed: _____

Suggested Resolution:

Signed: _____

This form is compliments of Clark County Public Health

This page left blank intentionally

Appendix XI

Case Closure forms

Example #	Agency
1	Clark County Public Health
2	Evergreen AIDS Foundation

This page left blank intentionally

YOUR AGENCY NAME
HIV/AIDS Program
Case Management Services

CASE CLOSURE

Client Name: _____

Other names known by: _____

DOB: _____ (mm/dd/year) **Social Security #:** _____

Last date seen: _____ (mm/dd/year) **Date of Closure:** _____ (mm/dd/year)

REASON FOR CLOSURE

1. **Client specifically declines any further assistance.**
   - A. **No service necessary** _____
   - B. **No longer *Your Agency* Case Management involvement** _____

2. **Client moved from area or whereabouts unknown.**
   - A. **Moved to:** _____
   - B. **Reason:** _____
   - C. **Referral given to:** _____

3. **Client receiving case management assistance from other source in Washington State.**
   - A. **Where:** _____ **Telephone:** _____
   - B. **Reason for change:** _____
   - C. **Is follow-up necessary & frequency?** _____

4. **Death: Date of death (mm/dd/year)** _____

5. **Comments:** _____

Case Manager _____ **Date** _____ (mm/dd/year)

Program Supervisor _____ **Date** _____ (mm/dd/year)

This form is compliments of Clark County Public Health

This page left blank intentionally

Case Status Form

Name:	DOB:
Social Security #:	Client ID:

Case Inactive / Reason

Date:

☐ **Client has been inactive in Case Management for more than 180 days.**

☐ **Client states no services are necessary.**

Letter to client? ☐ Yes ☐ No

Comments:

Case Manager Signature:

Case Closure / Reason

Date:

☐ **No need for further assistance. ISP goal sufficiently met.**

☐ **Client specifically declines any further assistance from *Your Agency Name*.**

Letter to client? ☐ Yes ☐ No

☐ **Client moved from area.**

Referred to: _____

☐ **Unable to locate client. No contact for 3 months.**

☐ **Client deceased.**

Final arrangements completed? ☐ Yes ☐ No

Comments:

Case Manager Signature:

Case Re-Open / Reason

Date:

Current Issues / Concerns:

Circle when completed:

ROI Service Plan Comprehensive Assessment

Case Manager Signature:

This form is compliments of Evergreen AIDS Foundation

This page left blank intentionally

Appendix XII

Sample Chart forms

Example #	Agency	Form
1	Kitsap County Health District	Client Paperwork Checklist
2	Clark County Public Health	New Client Checklist
3	Clark County Public Health	Face Sheet
4	Clark County Public Health	Appointment Summary & Next Steps
5	Clark County Public Health	Health Update

This page left blank intentionally

CLIENT PAPERWORK CHECKLIST

Your appointment is on _____ at _____ am / pm
mm/dd/year

With _____ Telephone # _____

Please have the documents listed below ready before your scheduled appointment. If you are unable to get any of the information listed below, it will delay services. Services cannot be rendered unless all of the required paperwork is complete.

Required Paperwork for Initial Meeting-Medical Case Management:

____ Picture identification *(Washington driver's license, Washington state ID)*

____ Annual income statement

____ Insurance cards *(Medicare, Medicaid, EIP, WSHIP)*

____ Proof of residency *(Current Washington driver's license, Washington state ID, Utility bill/no cell phone, Lease/rental/mortgage agreement, Homeless Client statement)*

____ Proof of HIV status *(Original Western Blot test result, lab report showing measurable presence of HIV virus, letter with signature from physician that has been providing care stating client is HIV positive)*

____ All contact information *(Valid telephone numbers and addresses of emergency contacts and doctors)*

I look forward to meeting you and if you have any questions or need to reschedule your appointment please call the telephone number listed above.

Thank you!

This form is compliments of Kitsap County Health District

This page left blank intentionally

New Client Checklist

Client Name: _____ Case Manager: _____

ALL ITEMS MUST BE COMPLETED WITHIN 30 DAYS OF INTAKE DATE

- o Assessment form completely filled out, signed and dated
- o Rights and Responsibilities signed and dated by client and CM
- o Service Plan filled out and signed by client and CM
- o ROIs completed, signed and dated by client and CM
- o HIV+ or AIDS verification (Dear Dr. letter or medical record) in file

  Date verification notice sent to provider _____
- o HIPPA signed and dated by client
- o Case Closure Policy had been discussed with client
- o Service Eligibility Policy has been discussed with client

This form is compliments of Clark County Public Health

This page left blank intentionally

FACE SHEET

Name: _____

DOB: _____ **SSN:** _____

Phone #: _____ **Message #:** _____

Phone #: _____ **Message #:** _____

Phone #: _____ **Message #:** _____

Phone #: _____ **Message #:** _____

When is a good time to call: _____ **OK to leave a message?** ☐ **Yes** ☐ **No**

Address: _____

_____

_____

_____

Receive Mailings: ☐ **Yes** ☐ **No**

Dr: _____ **Phone #:** _____

PIC Code: _____

DSHS Worker: _____ **Phone #:** _____

SSA Worker: _____ **Phone #:** _____

Person to Contact in an Emergency: _____

Phone #: _____

Special Notes: _____

_____

_____

_____

This page left blank intentionally

YOUR AGENCY NAME OR LOGO

HIV/AIDS CASE MANAGEMENT
Street Address, City, State Zip, Phone # and Fax #

Appointment Summary & Next Steps

Case Manager: _____ Ext: _____

Appointment Summary:

Client to Do:

Case Manager to Do:

Notes:

Next Appointment:

Date: _____ Time: _____

This page left blank intentionally

YOUR AGENCY NAME OR LOGO

HIV/AIDS CASE MANAGEMENT

Street Address, City, State Zip, Phone # and Fax #

Dear Dr. _____ Date: _____

Health Update, Progress notes, Lab Results and Medication List Request.

The person named below is a patient of yours who also receives services from **Your Agency's Name** Case Management.

Please complete the health form below and return it with progress notes for the previous six months, lab results, and a list of current medications, if applicable. You may return these documents to us by mail at:

Your Agency Name
Street Address
City, State Zip
Or, you may fax them to **Your Agency's fax #**

Please remember to sign and date the bottom of this form.

_____
Case Manager Name

Patient:		**DOB:**
Latest CD4 Count:	**CD4%**	**Viral Load:**
Date of results:	**Date of last Doctor visit:**	
This patient is HIV+:	**AIDS diagnosed:**	
Opportunistic Infections:		
Current Medications:		
Physician's Signature:		**Date:**

This form is compliments of Clark County Public Health

This page left blank intentionally

Appendix XIII

Chart Review forms

Example #	Agency	Form
1	Washington State Department of Health (DOH)	Title XIX Case Management Chart Audit form
2	Evergreen AIDS Foundation	Case Manager Initial File Review
3	Evergreen AIDS Foundation	180 Day Chart Review

This page left blank intentionally

Title XIX Case Management Chart Audit Form

(Please complete one form per client)

Agency	Auditor	Date

PIC # : _____ **Case Manager:** _____

RELEASE OF INFORMATION

Is there a valid client signed Release of Information on file for the months billed?	**Yes**	**No**

Comments: _____

COMPREHENSIVE ASSESSMENT

Is the assessment complete?	**Yes**	**No**
If billed, does the date signed match month billed?	**Yes**	**No**

Comments: _____

SERVICE PLAN

Is there a service plan in the chart? It must be signed and dated by the client.	**Yes**	**No**

Comments: _____

PROGRESS NOTES

Does the progress notes discuss the reason for the case manager's interaction with the client for each month billed?	**Yes**	**No**
Does the progress notes describe the plans in place to be developed to meet unmet needs?	**Yes**	**No**
Is the progress notes entered in chronological order and signed by the case manager?	**Yes**	**No**

CLIENT CONTACT

Is there sufficient contact with client documented in progress notes?	**Yes**	**No**

HIV VERIFICATION

Is there a signed document obtained from a provider that the client is HIV positive in chart?	**Yes**	**No**

MISCELLANEOUS

Is there documentation in the file notifying client of free choice of statewide case management providers?	**Yes**	**No**
Is the chart tidy and well organized?	**Yes**	**No**

Review progress notes and service plan for months billed and place a check in each box if:

- **Service plan is in file and has been reviewed and updated (SP)**
- **Progress notes support billing (P)**
- **Release of information is current (R)**

SP	P	R	Month	SP	P	R	Month	SP	P	R	Month	SP	P	R	Month

F= Full Month **P= Partial Month** **C= Comprehensive Assessment** **D= Denied**

ADDITIONAL COMMENTS/SUGGESTIONS: _____

This page left blank intentionally

Case Manager Initial File Review

Assigned Case Manager: _____

Date of review: _____
mm/dd/year

Intake Date: _____ Intake Complete: ☐ **Yes** ☐ **No**
mm/dd/year

If no, what needs to be completed? _____

_____

_____

Proof of ID: ☐ **Yes** ☐ **No**

Proof of Income: ☐ **Yes** ☐ **No**

Signed Policies and Procedures: ☐ **Yes** ☐ **No**

HIV Verification complete: ☐ **Yes** ☐ **No**

HIV Verification request made: ☐ **Yes** ☐ **No**

ROI complete: ☐ **Yes** ☐ **No**

Medication List complete: ☐ **Yes** ☐ **No**

Adherence Checklist complete: ☐ **Yes** ☐ **No**

Labs requested: ☐ **Yes** ☐ **No**

Proof of Insurance: ☐ **Yes** ☐ **No**

ISP complete: ☐ **Yes** ☐ **No**

ISP signed: ☐ **Yes** ☐ **No**

SAM complete: ☐ **Yes** ☐ **No**

Suggestions for ISP: _____

_____

_____

Comprehensive Assessment complete: ☐ **Yes** ☐ **No**

CA signed and dated: ☐ **Yes** ☐ **No**

Additional Comments: _____

_____

Reviewer Signature **Date (mm/dd/year)**

This form is compliments of Evergreen AIDS Foundation

This page left blank intentionally

180 Day Chart Review

Case Manger: _____ Client: _____

Date of Review: _____ Service Period: _____
mm/dd/year

	Yes	No	N/A	Observations/Action
Eligibility				
HIV Verification				
Income Verification				
Residency				
Medical Indicators				
Insurance Verification				
Proof of PCP/ID Engagement				
Adherence Check				
Client Information				
Acknowledgement/Consent Form				
Signed ROI in service period				
Intake/CA				
Closure				
Individual Service Plan				
Initial ISP				
Updated ISP				
Non-Continuous Service Forms				
Acuity				
Progress Notes**	**E**	**A**	**NI**	
Clinically Appropriate/MCM Indicators				
Relate to ISP				
Timely				

**** (Excellent / Acceptable / Needs Improvement)**

This form is compliments of Evergreen AIDS Foundation

Conclusions / Case Manager Follow-Up:

☐ Discussed with CM ☐ Review Open Date Review Closed: _____
mm/dd/year

_____ _____
Clinical Supervisor / Date Executive Director / Date

Appendix XIV

Chart Arrangement examples

This page left blank intentionally

Client Chart Arrangement

The following information on client chart arrangement is provided as a reference/guidance for agencies. This is not a "mandatory" arrangement and agencies will not be penalized during chart audits/assist visits for not following this reference/ guidance. We are simply providing a compilation of what most agencies are utilizing currently and trying to standardize the layout. This will ensure that if/when a patient transfers to another agency, a case manager wins the lottery and never comes back to work or during a Department of Health (DOH) audits/assist visits we can all find the client's information effortlessly, which ultimately ensure continuity of care for the client.

Most agencies have their charts arranged in one of two formats; three ring binders or 6 to 8 section folders. Either way is acceptable and most importantly it is what works best for your agencies needs and space requirements.

3 Ring Binder Arrangement

When you first open the binder it is important to have a Client Demographics/Face sheet that holds key client information (name, client ID#, SSN, DOB, age, Address, Emergency Contact, Physician, etc.). In addition, a Records Date Sheet can also save valuable time by recording all pertinent dates on one page. Lastly in the first part of your binder having a Table of Contents will also assist case managers and DOH personnel perform their duties in a timely manner. The following is a guideline for the individual sections:

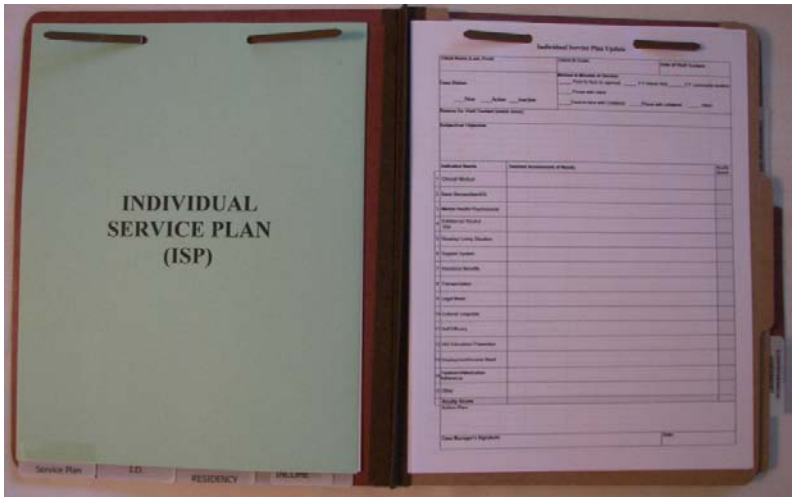
Tab/Section	Forms/Documents
Intake/Assessment	• Intake • Comprehensive Assessment • HIV/AIDS Verification • Reassessment • Client Update • Consent for Services • Client's Rights and Responsibilities • Grievance Policy
Service Plan	• Individualized Service Plan (ISP)
Progress Notes	• Progress Notes (If these are kept electronically, a word document that maps the exact location of the progress notes should be inserted here)
Insurance	• Insurance paperwork & copies of ID cards

Tab/Section	Forms/Documents
Income	• Copies of Income verification
Adherence	• Treatment/Medication Adherence
Mental Health	• Coordination of Care Memo • Pertinent documentation
Legal	• Any legal documentation (immigration, court, jail, prison, etc.)
Housing	• Copies of Proof of Residence • Coordination of Housing Memo • Homeless Client Statement (if pertinent) • Pertinent documentation
Correspondence	• Appointment summary
Release Forms	• Release of Information (ROI)
HIPAA	• Signed HIPAA document

6 Section Folder Arrangement

Just like in the 3 ring binder format it is important to have a Client Demographics/Face sheet when you first open the folder, preferably on the left hand side. When utilizing the 6 section folder arrangement it is vital to label all tabs with section name for easy reference. The following is a guideline for the individual sections:

First Section



The left side, which has separate labeled/tabs located within the section, contains:

- Client Demographics/Face Sheet
- ISP (separate tab)
- Identification (separate tab)
- Residency (separate tab)
- Income (separate tab)

The right side contains:

- ISP Updates
- Progress Notes (If these are kept electronically, a word document that maps the exact location of the progress notes should be inserted here)

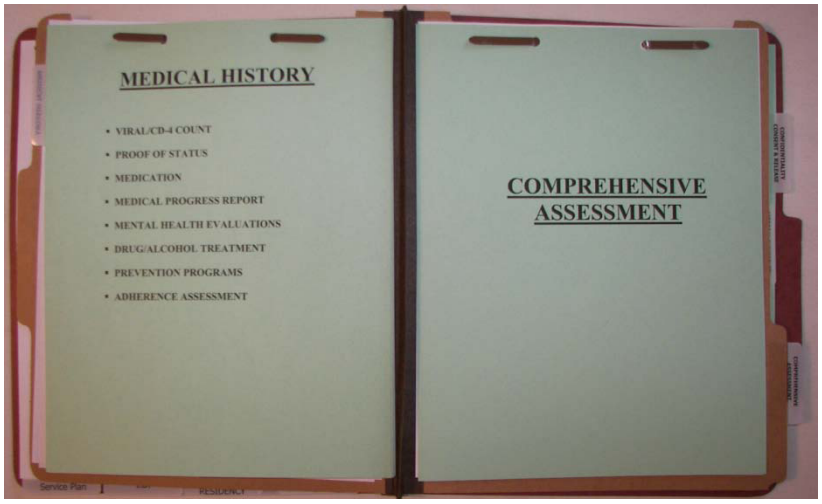
Second Section

The left side, medical history, contains:

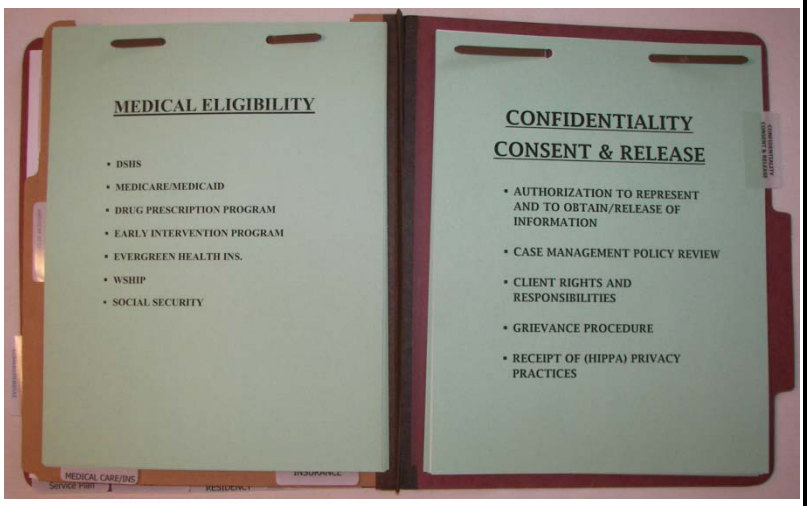
- Viral/CD4 Count
- Proof of Status
- Medication
- Medical Progress Report
- Mental Health Evaluations
- Drug/Alcohol Treatment
- Prevention Programs
- Adherence Assessment

The right side, comprehensive assessment, contains:

- Intake
- Comprehensive Assessment
- Reassessment
- Client Update



Third Section



The left side, medical eligibility contains:

- DSHS
- Medicare/Medicaid
- ADAP/EIP/EHIP/WSHIP
- Social Security

The right side, confidentiality, consent & ROI, contains:

- ROI
- Consent for Services
- Client's Rights and Responsibilities
- Grievance Policy
- Signed HIPAA document

Again these are only provided as a reference for agencies and are not mandatory in any way. If your agency has a format that works and provides an organized reference, then your agency is in compliance with the standards. Additionally if your agency would like more guidance or clarification please do not hesitate to contact your contract manager at DOH for assistance.

Client Chart Arrangement ideas compliments of Grant County Health District, Clark County Public Health, Coastal Community Action Program, Okanogan County Public Health and Evergreen AIDS Foundation.

This page left blank intentionally

Appendix XV

Appropriate WACs & RCWs

WAC or RCW	#
WAC	388-539-0300
WAC	388-539-0350
RCW	70.02.030
RCW	71.05.120

This page left blank intentionally

WAC 388-539-0300
Case management for persons living with HIV/AIDS.

The department provides HIV/AIDS case management to assist persons infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

(1) To be eligible for department reimbursed HIV/AIDS case management services, the person must:

(a) Have a current medical diagnosis of HIV or AIDS;

(b) Be eligible for Title XIX (Medicaid) coverage under either the categorically needy program (CNP) or the medically needy program (MNP); and

(c) Require:

(i) Assistance to obtain and effectively use necessary medical, social, and educational services; or

(ii) Ninety days of continued monitoring as provided in WAC 388-539-0350(2).

(2) The department has an interagency agreement with the Washington state department of health (DOH) to administer the HIV/AIDS case management program for the department's Title XIX (Medicaid) clients.

(3) HIV/AIDS case management agencies who serve the department's clients must be approved to perform these services by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive persons of their statewide choice of available HIV/AIDS case management providers and document that notification in the client's record. This notification requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services.

(b) Have a current client-signed authorization to release/obtain information form. The provider must have a valid authorization on file for the months that case management services are billed to the department (see RCW 70.02.030). The fee referenced in RCW 70.02.030 is included in the department's reimbursement to providers. The department's clients may not be charged for services or documents related to covered services.

(c) Maintain sufficient contact to ensure the effectiveness of ongoing services per subsection (5) of this section. The department requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the individual service plan (ISP).

(5) HIV/AIDS case management providers must document services as follows:

(a) Providers must initiate a comprehensive assessment within two working days of the client's referral to HIV/AIDS case management services. Providers must complete the assessment before billing for ongoing case management services. If the assessment does not meet these requirements, the provider must document the reason(s) for failure to do so. The assessment must include the following elements as reported by the client:

(i) Demographic information (e.g., age, gender, education, family composition, housing.);

(ii) Physical status, the identity of the client's primary care provider, and current information on the client's medications/treatments;

(iii) HIV diagnosis (both the documented diagnosis at the time of assessment and historical diagnosis information);

(iv) Psychological/social/cognitive functioning and mental health history;

(v) Ability to perform daily activities;

(vi) Financial and employment status;

(vii) Medical benefits and insurance coverage;

(viii) Informal support systems (e.g., family, friends and spiritual support);

(ix) Legal status, durable power of attorney, and any self-reported criminal history; and

(x) Self-reported behaviors which could lead to HIV transmission or re-infection (e.g., drug/alcohol use).

(b) Providers must develop, monitor, and revise the client's individual service plan (ISP). The ISP identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs. The case manager and the client must develop the ISP within two days of the comprehensive assessment or the provider must document the reason this is not possible. An ISP must be:

(i) Signed by the client, documenting that the client is voluntarily requesting and receiving the department reimbursed HIV/AIDS case management services; and

(ii) Reviewed monthly by the case manager through in-person or telephone contact with the client. Both the review and any changes must be noted by the case manager:

(A) In the case record narrative; or

(B) By entering notations in, initialing and dating the ISP.

(c) Maintained ongoing narrative records - These records must document case management services provided in each month for which the provider bills the department. Records must:

(i) Be entered in chronological order and signed by the case manager;

(ii) Document the reason for the case manager's interaction with the client; and

(iii) Describe the plans in place or to be developed to meet unmet client needs.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-539-0300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0300, filed 11/16/00, effective 12/17/00.]

http://apps.leg.wa.gov/WAC/default.aspx?cite=388-539-0300

WAC 388-539-0350
HIV/AIDS case management reimbursement information.

(1) The department reimburses HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment - The assessment must cover the areas outlined in WAC 388-539-0300 (1) and (5).

(i) The department reimburses only one comprehensive assessment unless the client's situation changes as follows:

(A) There is a fifty percent change in need from the initial assessment; or

(B) The client transfers to a new case management provider.

(ii) The department reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is Medicaid eligible and the ongoing case management has been provided.

(b) HIV/AIDS case management, full-month - Providers may request the full-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. The department reimburses only one full-month case management fee per client in any one month.

(c) HIV/AIDS case management, partial-month - Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an ISP in place for fewer than twenty days in that month. Using the partial-month reimbursement, the department may reimburse two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) The department limits reimbursement to HIV/AIDS case managers when a client becomes stabilized and no longer needs an ISP with active service elements. The department limits reimbursement for monitoring to ninety days past the time the last active service element of the ISP is completed. Case Management providers who are monitoring a stabilized client must meet all of the following criteria in order to bill the department for up to ninety days of monitoring:

(a) Document the client's history of recurring need;

(b) Assess the client for possible future instability; and

(c) Provide monthly monitoring contacts.

(3) The department reinstates reimbursement for ongoing case management if a client shifts from monitoring status to active case management status due to documented need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-539-0350, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0350, filed 11/16/00, effective 12/17/00.]

This page left blank intentionally

RCW 70.02.030
Patient authorization of disclosure.

(1) A patient may authorize a health care provider or health care facility to disclose the patient's health care information. A health care provider or health care facility shall honor an authorization and, if requested, provide a copy of the recorded health care information unless the health care provider or health care facility denies the patient access to health care information under RCW 70.02.090.

(2) A health care provider or health care facility may charge a reasonable fee for providing the health care information and is not required to honor an authorization until the fee is paid.

(3) To be valid, a disclosure authorization to a health care provider or health care facility shall:

(a) Be in writing, dated, and signed by the patient;

(b) Identify the nature of the information to be disclosed;

(c) Identify the name and institutional affiliation of the person or class of persons to whom the information is to be disclosed;

(d) Identify the provider or class of providers who are to make the disclosure;

(e) Identify the patient; and

(f) Contain an expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure.

(4) Unless disclosure without authorization is otherwise permitted under RCW 70.02.050 or the federal health insurance portability and accountability act of 1996 and its implementing regulations, an authorization may permit the disclosure of health care information to a class of persons that includes:

(a) Researchers if the health care provider or health care facility obtains the informed consent for the use of the patient's health care information for research purposes; or

(b) Third-party payers if the information is only disclosed for payment purposes.

(5) Except as provided by this chapter, the signing of an authorization by a patient is not a waiver of any rights a patient has under other statutes, the rules of evidence, or common law.

(6) When an authorization permits the disclosure of health care information to a financial institution or an employer of the patient for purposes other than payment, the authorization as it pertains to those disclosures shall expire ninety days after the signing of the authorization, unless the authorization is renewed by the patient.

(7) A health care provider or health care facility shall retain the original or a copy of each authorization or revocation in conjunction with any health care information from which disclosures are made.

(8) Where the patient is under the supervision of the department of corrections, an authorization signed pursuant to this section for health care information related to mental health or drug or alcohol treatment expires at the end of the term of supervision, unless the patient is part of a treatment program that requires the continued exchange of information until the end of the period of treatment.

[2005 c 468 § 3; 2004 c 166 § 19; 1994 sp.s. c 9 § 741; 1993 c 448 § 3; 1991 c 335 § 202.]

Notes:

Severability -- Effective dates -- 2004 c 166: See notes following RCW 71.05.040.

Severability -- Headings and captions not law -- Effective date -- 1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

Effective date -- 1993 c 448: See note following RCW 70.02.010.

http://apps.leg.wa.gov/RCW/default.aspx?cite=70.02.030

This page left blank intentionally

RCW 71.05.120
Exemptions from liability.

(1) No officer of a public or private agency, nor the superintendent, professional person in charge, his or her professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any *county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.

(2) This section does not relieve a person from giving the required notices under RCW 71.05.330(2) or 71.05.340(1)(b), or the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.

[2000 c 94 § 4; 1991 c 105 § 2; 1989 c 120 § 3; 1987 c 212 § 301; 1979 ex.s. c 215 § 7; 1974 ex.s. c 145 § 7; 1973 2nd ex.s. c 24 § 5; 1973 1st ex.s. c 142 § 17.]

Notes:

***Reviser's note:** The term "county designated mental health professional" as defined in RCW 71.05.020 was changed to "designated mental health professional" by 2005 c 504 § 104.

Severability -- 1991 c 105: See note following RCW 71.05.215.

http://apps.leg.wa.gov/RCW/default.aspx?cite=71.05.120#

This page left blank intentionally

Appendix XVI

Title XIX (Medicaid) HIV/AIDS Case Management Billing Instructions

This page left blank intentionally

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Department of Health (DOH)
and
Health and Recovery Services Administration (HRSA)

Title XIX (Medicaid) HIV/AIDS Case Management

Billing Instructions

ProviderOne Readiness Edition

[Chapter 388-539-0300 and 0350 WAC]

About This Publication

This publication supersedes all previous Department *Title XIX (Medicaid) HIV/AIDS Case Management Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services.

This document is to be used for billing purposes only. Please refer to the Department of Health's *Statewide Standards for Medical HIV Case Management* (DOH publication #410-014) for a complete guide to the HIV/AIDS Case Management Program. Refer to the *Important Contacts* section of these billing instructions to find out how to order this DOH publication.

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Page Affected

Table of Contents

Important Contacts

Note: This section contains important contact information relevant to the HIV/AIDS Case Management program. For more contact information, see the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider	Department of Health HIV Client Services 1-360-236-3453
Submitting a change of address or ownership	See the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
Questions about provider participation, case management standards, and reporting requirements	Department of Health HIV Client Services PO Box 47841 Olympia WA 98501-7841 1-360-236-3453
Getting a copy of DOH's *Statewide Standards for Medical HIV Case Management?*	Department of Health HIV Client Services PO Box 47841 Olympia WA 98504-7841 1-360-236-3453 http://www.doh.wa.gov/cfh/HIV%5FAIDS/Client%5FSvcs/TitleXIXHIVCM.htm

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

AIDS - Acquired Immunodeficiency Syndrome. A disease caused by the Human Immunodeficiency Virus (HIV).

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Department of Health (DOH) - The state Department of Health which, in accordance with an interagency agreement, administers the daily operations of Title XIX targeted HIV/AIDS case management.

HIV - Human Immunodeficiency Virus.

HIV/AIDS Case Management - Services which assist persons infected with HIV to: live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

HIV Client Services - The office of the Division of Community & Family Health, Department of Health, which oversees the daily operation of the Title XIX HIV/AIDS Case Management Program.

ISP – Individual Service Plan – Identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs.

Maximum Allowable - The maximum dollar amount that the Department will pay a provider for specific services, supplies, and equipment.

Medical Identification card(s) – See *Services Card*.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

About the Program

What Is the Purpose of the Title XIX (Medicaid) HIV/AIDS Case Management Program? [Refer to WAC 388-539-0300]

The purpose of the Title XIX HIV/AIDS case management program is to assist persons infected with HIV to:

- Live as independently as possible;
- Maintain and improve health;
- Reduce behaviors that put the client and others at risk; and
- Gain access to needed medical, social, and educational services.

The Department of Social & Health Services (the Department) has an interagency agreement with the Department of Health (DOH) to administer the HIV/AIDS Case Management program for eligible Department clients. [Refer to WAC 388-539-0300(2)]

Who Provides Title XIX HIV/AIDS Case Management Services? [Refer to WAC 388-539-0300(3)]

Agencies approved by DOH's HIV Client Services.

How Does an Agency Request Approval from DOH to Provide These Services?

An agency requests approval from DOH by completing all of the steps in the Title XIX Provider Application Process and submitting all required documents to DOH.

Where Can an Agency Get the Information Needed to Complete the Provider Application Process?

Refer to DOH's: ***Statewide Standards for Medical HIV Case Management*** for specifics on provider requirements, or call HIV Client Services at 1-360-236-3453. Refer to *Important Contacts* for information on ordering a copy of this DOH publication.

Client Eligibility

Who Is Eligible to Receive Title XIX HIV/AIDS Case Management? [Refer to WAC 388-539-0300(1)]

To be eligible for Title XIX-paid HIV/AIDS case management services, an individual must:

- Have a current medical diagnosis of HIV or AIDS;
- **Not be receiving** concurrent Title XIX HIV/AIDS case management services through another program;
- Require:
  - ✓ Assistance to obtain and effectively use necessary medical, social, and educational services; or
  - ✓ 90 days of continued monitoring (see Section C for more information).

-AND-

- Have a Benefit Service Package that covers HIV/AIDS Case Management.

> **Note:** Refer to the *Scope of Coverage Chart* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063 for GAU clients]

YES, provided the client meets the criteria on the previous page. When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. HIV/AIDS Case Management services do not require a referral from the client's managed care plan. Use these billing instructions to bill the Department directly.

Billable Services

What Services Are Billable?

The Department pays Title XIX HIV/AIDS case management providers for the following three services when performed in an office setting or the client's residence:

1. Comprehensive Assessment

The Department pays for only one comprehensive assessment per client unless the client's situation changes as follows:

a. There is a 50% change in need from the initial assessment; or
b. The client transfers to a new case management provider.

The assessment must cover the areas outlined in DOH's **Case Management: A Guide for Assisting Persons Living with HIV/AIDS.** [Also listed in WAC 388-539-0300(1) and (5)]

The Department pays for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is eligible for Medical Assistance and the ongoing case management has been provided.

2. HIV/AIDS Case Management – Full Month

The Department pays for one full-month case management fee per client, per month.

Providers may request the full-month payment for any month in which the criteria listed in DOH's *Case Management: A Guide for Assisting Persons Living with HIV/AIDS* have been met and the case manager has an individual service plan (ISP) in place for 20 or more days in that month. [The criteria are also listed in WAC 388-539-0300.] Monitoring can be billed under this service.

3. HIV/AIDS Case Management – Partial Month

Providers may request the partial-month payment for any month in which the criteria in WAC 388-539-0300 have been met and an ISP has been in place for fewer than 20 days in that month. Monitoring can be billed under this service.

Partial month payment allows for payment of two case management providers when a client changes from one provider to another during the month.

When Is Monitoring a Billable Service?

Monitoring is a term used when a client becomes stabilized and no longer needs an Individual Service Plan (ISP) with active elements. This applies to clients who have a history of recurring need and instability and will likely require further assistance at a later date.

Case management providers may bill the Department for up to 90 days of monitoring past the time the last active service element of the ISP has been completed and the following criteria have been met:

- Document the client's history of recurring need;
- Assess the client for possible future instability; and
- Provide monthly monitoring contacts.

What Procedure Codes Must Be Used to Bill the Department for Monitoring?

Use the following procedure codes, modifiers, and taxonomies to bill the Department for monitoring:

HCPCS Code	Modifier	Description
T2022 Limited to dx 042 or V08	U8*	**Case management, per month.** Full month case management services Taxonomy: 251B00000X
T2022 Limited to dx 042 or V08	U9*	**Case management, per month.** Partial month case management services Taxonomy: 251B00000X

*Modifiers U8 and U9 are payer-defined modifiers. The Department defines modifier U8 as "full month" and U9 as "partial month."

When Can a Client Be Reinstated from a Monitoring Status to Active Case Management?

A client can shift from monitoring status (ISP without active elements) to active case management status upon documentation of need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

Coverage Table

Use the following procedure codes with the appropriate modifiers when billing for Title XIX HIV/AIDS case management services:

Procedure Code	Modifier	Diagnosis Code	Brief Description	Policy/ Comments
T2022	U8	Limited to 042 or V08	Case management, per month.	**[Full Month]** A full-month rate applies when: A. The criteria in WAC 388-539-0300 have been met; and B. An individual service plan (ISP) has been in place 20 days or more in that month. Taxonomy: 251B00000X
T2022	U9	Limited to diagnosis 042 or V08	Case management, per month.	**[Partial Month]** A partial month rate applies when: A. The criteria is WAC 388-539-0300 have been met; and B. An ISP has been in place fewer than 20 days in that month. Taxonomy: 251B00000X
Note: The Department pays full or partial month fees during monitoring per WAC 388-539-0350.				
T1023		Limited to diagnosis 042 or V08	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter.	**(Use this code for the comprehensive assessment)** This service must meet the requirements of WAC-539-0300 (1) and (5) and is paid only ***once*** unless the client's condition changes as follows: A. There is a 50% change in need from the initial assessment; or B. The client transfers to a new case management provider. A comprehensive assessment is paid in addition to a monthly charge (either full or partial) if the assessment is completed during the month a client is Medicaid eligible and ongoing case management has been provided. Taxonomy: 251B00000X

Fee Schedule

You may view the Department/HRSA HIV/AIDS Case Management Fee Schedule on-line at: http://hrsa.dshs.wa.gov/RBRVS/Index.html#h

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

What Additional Records Must Be Kept Specific to the Title XIX HIV/AIDS Case Management Program?

Please refer to the Department of Health's **Case Management: A Guide for Assisting Persons Living with HIV/AIDS** for required documentation specific to the Title XIX HIV/AIDS Case Management Program.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

Appendix XVII

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

This page left blank intentionally

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

CLAS Standards - the collective set of culturally and linguistically appropriate services (CLAS) mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes:

Culturally Competent Care (Standards 1-3)

Language Access Services (Standards 4-7)

Organizational Supports for Cultural Competence (Standards 8-14)

Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1 Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2 Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3 Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4 Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5 Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6 Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7 Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8 Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9 Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10 Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11 Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12 Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13 Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14 Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

For more information, visit:

- Cultural Competency Website of the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH)
- National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care (Final Report) (PDF)
- National Standards for Culturally and Linguistically Appropriate Services in Health Care (Executive Summary) (PDF)
- Normas nacionales para servicios cultural y lingüísticamente apropiados en la atención sanitaria (Resumen ejecutivo) (PDF)

Appendix XVIII

Important Web Links

This page left blank intentionally

IMPORTANT WEB LINKS

Global

AIDS Education Global Information System (AEGIS)

http://www.aegis.com/

Federal Agencies

AIDS.Gov

http://www.aids.gov/

Centers for Disease Control and Prevention

http://cdc.gov/

Office of National AIDS Policy

http://www.whitehouse.gov/administration/eop/onap/

U.S. Department of Health & Human Services-Food and Drug Adminastration (FDA) HIV/AIDS

http://www.fda.gov/ForConsumers/byAudience/ForPatientAdvocates/HIVandAIDSActivities/default.htm

U.S. Department of Health & Human Services-Health Resources & Service Adminastration (HRSA)

http://www.hab.hrsa.gov/

National Agencies

Target Center

http://www.careacttarget.org/

National Alliance of State & Territorial AIDS Directors (NASTAD)

http://www.nastad.org/default.aspx

National Quality Center (NQC)

http://nationalqualitycenter.org/

The Body (The Complete HIV/AIDS Resource)

http://www.thebody.com/

State Agencies

Washington State Department of Health (DOH)

http://www.doh.wa.gov/

DOH HIV/AIDS

http://www.doh.wa.gov/cfh/hiv/default.htm

DOH EIP/ADAP

http://www.doh.wa.gov/cfh/hiv/care/default.htm

State Agencies Continued

Washington State Department of Social & Health Services (DSHS)

http://www.dshs.wa.gov/

DSHS Provider One

http://hrsa.dshs.wa.gov/providerone/providers.htm

County Agencies / Local Health Jurisdictions (LHJ)

Benton-Franklin Health District

http://www.bfhd.wa.gov/base/index.php

Chelan-Douglas Health District

http://www.cdhd.wa.gov/

Clallam County Health & Human Services

http://www.clallam.net/HHS/

Clark County Public Health

http://www.co.clark.wa.us/public-health/hiv/case.html

Cowlitz County Health Department

http://www.co.cowlitz.wa.us/health/

Grant County Public Health

http://granthealth.org/

Kitsap County Health District

http://www.kitsapcountyhealth.com/

Mason County Public Health

http://www.co.mason.wa.us/health/community_health/index.php

Okanogan County Public Health

http://www.okanogancounty.org/ochd/

Public Health-Seattle & King County (PHSKC)

http://www.kingcounty.gov/healthservices/health/communicable/hiv.aspx

Spokane Regional Health District

http://www.srhd.org/

Community Based Organizations (CBO)

Blue Mountain Heart to Heart

http://www.bluemountainheart.org/

Coastal Community Action Program (CCAP)

http://coastalcap.org/

Consejo

http://consejocounseling.org/

Community Based Organizations (CBO) Continued

Evergreen AIDS Foundation

http://www.evergreenaids.org/

Lifelong AIDS Alliance

http://www.lifelongaidsalliance.org/

Pierce County AIDS Foundation (PCAF)

http://www.piercecountyaids.org/

People of Color Against AIDS Network (POCAAN)

http://www.pocaan.org/home.html

Spokane AIDS Network

http://san-nw.org/

United Communities Against AIDS Network (UCAN)

http://www.ucan-wa.org/WordPress/

Part C Clinics

Community Health Association of Spokane

http://www.chas.org/

County Doctor

http://www.countrydoctor.org/

Harborview Madison Clinic

http://depts.washington.edu/madclin/

Interfaith Community Health Center

http://www.interfaithchc.org/medical-services

New Hope Clinic

http://www.thebody.com/content/art1874.html

Yakima Valley Farm Workers Clinic

http://yvfwc.com/

Insurance

Evergreen Health Insurance Program

http://ehip.org/

Ramsell Public Health Rx

http://www.publichealthrx.com/

Washington State Health Insurance Pool (WSHIP)

https://wship.org/Default.asp